64TH ANNUAL MEETING · CHICAGO · SEPT. 17-20

HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

OCTOBER 16, 1961

HURRICANE CARLA: SEVERE TEST FOR TEXAS HOSPITALS

(See NEWS, page 114)

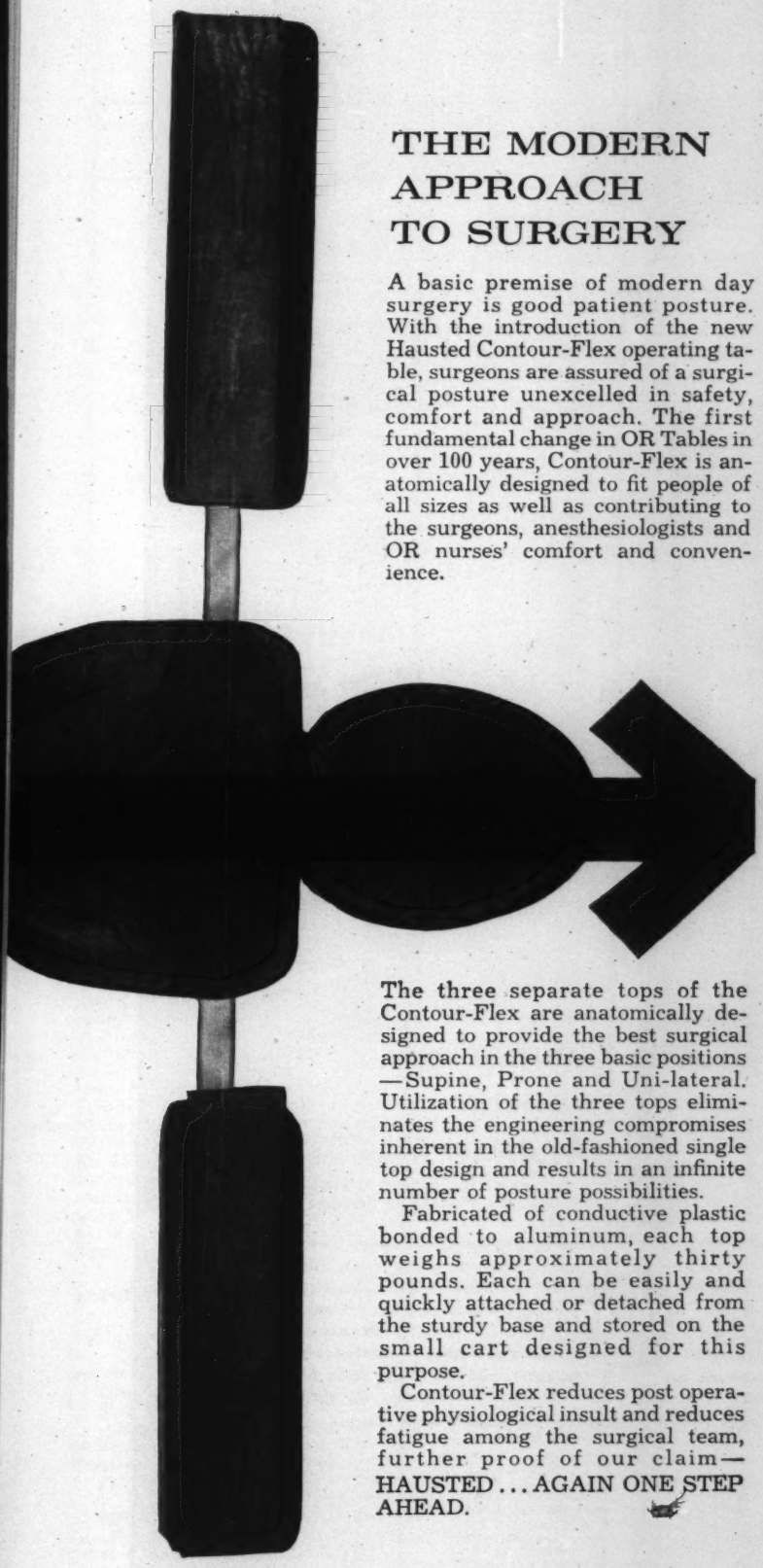
HAUSTED

CONTOUR-FLEX

Surgical operating tables

Please write for complete details on Contour-Flex

SIMMONS COMPANY
HAUSTED DIVISION
MEDINA, OHIO



THE MODERN APPROACH TO SURGERY

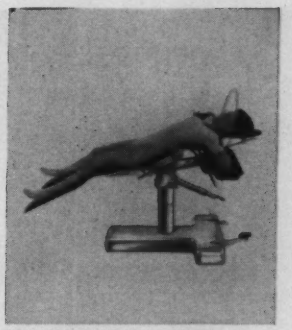
A basic premise of modern day surgery is good patient posture. With the introduction of the new Hausted Contour-Flex operating table, surgeons are assured of a surgical posture unexcelled in safety, comfort and approach. The first fundamental change in OR Tables in over 100 years, Contour-Flex is anatomically designed to fit people of all sizes as well as contributing to the surgeons, anesthesiologists and OR nurses' comfort and convenience.

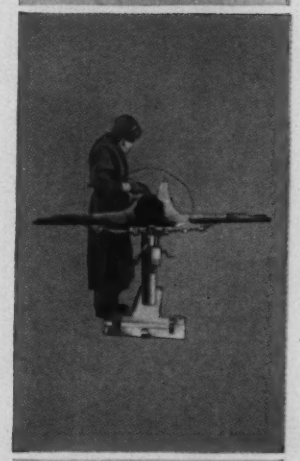
The three separate tops of the Contour-Flex are anatomically designed to provide the best surgical approach in the three basic positions —Supine, Prone and Uni-lateral. Utilization of the three tops eliminates the engineering compromises inherent in the old-fashioned single top design and results in an infinite number of posture possibilities.

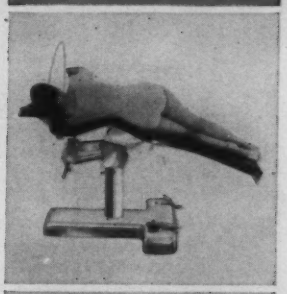
Fabricated of conductive plastic bonded to aluminum, each top weighs approximately thirty pounds. Each can be easily and quickly attached or detached from the sturdy base and stored on the small cart designed for this purpose.

Contour-Flex reduces post operative physiological insult and reduces fatigue among the surgical team, further proof of our claim—

HAUSTED . . . AGAIN ONE STEP AHEAD.







improved
model
SKLAR electric
evacuator for Wangensteen Technique
Cat. No. 100-180 (Illustrated) with 32 oz. irrigating bottle.
Cat. No. 100-182, without irrigating bottle.
The improved Sklar Electric Evacuator meets every demand for continuous, low grade-suction and pressure. It may be regulated to meet the individual patient's requirements; thus, assuring maximum comfort and highly satisfactory clinical results. The Sklar Electric Evacuator is designed specifically for finely controlled, continuous suction and pressure in such procedures as: stomach evacuation, intestinal decompression, thoracic drainage, prostatectomy, gastric lavage, fistula drainage, and bladder irrigation. The versatility of this new model eliminates the need for highly specialized equipment. No maintenance or lubrication required — guaranteed for two years. Available through Sklar Surgical Supply Distributors. Send for descriptive literature and specifications.
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J. Sklar Manufacturing Co., 38-04 Woodside Avenue, Long Island City 4, New York

HOSPITALS

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cover

A makeshift hospital was put together in the gymnasium of the Lamar State College of Technology, Beaumont, Tex. Within 48 hours, this hospital, supervised by volunteer professional persons, was housing 250 patients. For a comprehensive story on how hospitals coped with the emergency caused by Hurricane Carla, see page 114. Cover photo by the *Beaumont* (Tex.) *Journal*. (Other photo credits in this issue are on page 128.)

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NEW PERMACRYLIC* PRODUCT THAT CUTS MAINTENANCE

1 LOCK IT ON...FINISH LASTS AS LONG AS YOU WANT!

YOU CAN SCRUB IT

Scrub-clean "Lock-and-Key" all you want, because regular floor cleaners remove only the dirt but not the finish. "Lock-and-Key" keeps on shining—never needs buffing.

"LOCK-AND-KEY"* FLOOR FINISH comes in 1-, 5-, 30- and 55-gallon sizes.

GREAT NEW CHEMICAL DISCOVERY CUTS FLOOR MAINTENANCE TIME AND COSTS!

Here's the greatest advance in floor coatings since the introduction of vinyl finishes by Simoniz in 1953.

"Lock-and-Key" is a brand-new, *completely different*, Permacrylic product that solves a major maintenance problem. It has permanent resistance to alkaline cleaners and water—can be re-coated time and time again—*yet* is easily removable.

This means that "Lock-and-Key" can be cleaned with common cleaning and sanitizing agents, over and over, without dulling or damaging the polish—and no buffing is ever required. Spills, scuffing, grime, grease and grit cannot wear it away. "Lock-and-Key" lasts as long as you want it to.

(*)—Trade-marks of Simoniz Company

FLOOR FINISH

COSTS IN HALF!

IT'S EASY TO REMOVE

Zip off in minutes with special "Lock-and-Key" Remover when you want to re-coat completely. Just mop the floor—no scrubbing machine needed—comes off 4 times faster than old-fashioned stripping methods.

2 UNLOCK IT...IT ZIPS OFF 4 TIMES FASTER!

YOU CAN RE-COAT IT

Re-coat "Lock-and-Key" whenever you want without stripping. It will not yellow, discolor or powder. Shine gets even better—protection lasts longer—with every coat.

IT'S LONGER-LASTING

New "Lock-and-Key" Floor Finish provides protection and beauty longer than any product ever could before. Most durable, most easy-to-maintain floor finish ever formulated.

"LOCK-AND-KEY" REMOVER comes in 20-oz., 1- and 5-gallon sizes.

"Lock-and-Key" can be re-coated whenever you want without yellowing or discoloration. With each new coat you deepen the gloss and extend the protection.

The finish lasts and lasts and lasts—yet you can remove it whenever you want, without a machine, merely by mopping the floor with the special "Lock-and-Key" Remover.

Long life, easier maintenance, simple removal: these are the benefits of this great new, *completely different*, Simoniz "Lock-and-Key" Floor Finish. They add up, not only to improved appearance, but to greatly reduced maintenance costs for all floors.

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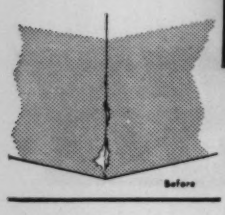

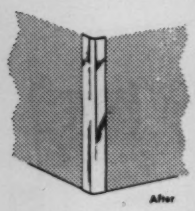

Any exposed corner can be repaired and protected permanently and inexpensively — in just a few minutes!

Wilkinson Stainless Steel Corner Guards are applied by a special mastic cement. No preparation of the wall is necessary except to remove loose particles and dust. Models to fit any corner angle.

Wilkinson Cement-On Corner Guards are used extensively in VA Hospitals.

Stick-On Corner Guards also available for areas subject to less abuse.

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hospital association meetings

AMERICAN HOSPITAL ASSOCIATION

NATIONAL MEETINGS

1962

Jan. 31-Feb. 1—**Midyear Conference of Presidents and Secretaries,** Chicago (AHA Headquarters)

Sept. 17-20—**64th Annual Meeting,** Chicago (McCormick Place)

MEETING AND INSTITUTE

CALENDAR

THROUGH MARCH 1962

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

OCTOBER

16-17 ***National Council on the Aging,*** New York City

16-17 Idaho Hospital Association, Boise (Elks Lodge)

16-19 **Staffing Departments of Nursing,** Cincinnati (Sheraton-Gibson Hotel)

16-19 ***American Dental Association,*** Philadelphia (Sheraton Hotel and Convention Hall)

17-18 South Dakota Hospital Association, Sioux Falls (Sheraton-Cataract Hotel)

17-19 British Columbia Hospital Association, Vancouver (Hotel Vancouver)

19-20 Arizona Hospital Association, Phoenix (Ramada Inn)

19-21 West Virginia Hospital Association, Morgantown (Morgan Hotel)

22-24 Oregon Hospital Association, Eugene (Eugene Hotel)

22-25 Colorado Hospital Association and Wyoming Hospital Association, Boulder (Harvest House)

22-27 ***American Society of Anesthesiologists, Inc.,*** Los Angeles (Statler Hilton Hotel)

23-25 Ontario Hospital Association, Toronto (Royal York Hotel)

23-27 California Hospital Association, San Diego (El Cortez Hotel)

24-25 North Dakota Hospital Association, Jamestown

24-27 ***American Dietetic Association,*** St. Louis (Sheraton-Jefferson Hotel and Kiel Auditorium)

25-28 ***American Association of Blood Banks,*** Chicago (Drake Hotel)

26-27 Washington State Hospital Association, Yakima (Chinook Hotel)

27-28 Nevada Hospital Association, Lovelock (Pershing General Hospital)

NOVEMBER

1-3 Indiana Hospital Association, French Lick (French Lick Hotel)

2-3 Oklahoma Hospital Association, Tulsa (Mayo Hotel)

2-4 **Hospital Directors of Medical Education,** Chicago (AHA Headquarters)

6-8 ***American Occupational Therapy Association,*** Detroit (Sheraton-Cadillac Hotel)

6-8 **Hospital Pharmacy (Specialized),** Chicago (AHA Headquarters)

6-9 ***American Association of Inhalation Therapists,*** Buffalo, N.Y. (Statler-Hilton Hotel)

6-10 **Physical Therapists,** Miami Beach (Deauville Hotel)

8-10 Maryland-D.C.-Delaware Hospital Association, Washington (Shoreham Hotel)

9-10 Kansas Hospital Association, Hutchinson (Baker Hotel)

9-10 Minnesota Hospital Association, Minneapolis (Leamington Hotel)

9-10 Virginia Hospital Association, Richmond (John Marshall Hotel)

(Continued on page 8)

Swift's ENSTAPH

Ready-to-use, economical laundering compounds that fight staph and other bacteria <u>while linens are in use</u>

Swift's ENSTAPH offers four major advantages in your battle against *Staphylococcus aureus* and other bacteria:

1. Effective
2. Easy to use
3. Residual anti-bacterial protection
4. Low cost

Here's how each of these affect your operations:

EFFECTIVENESS

The Contact Plate Test and The Filtered Cell Test both show effectiveness against *Staphylococcus aureus*. In-use tests of soiled linens substantiate the findings. The filtered cell test also demonstrates ENSTAPH washed fabric is effective against *beta* hemolytic streptococci and salmonellae (including *Salmonella typhosa*). The anti-bacterial system in ENSTAPH is also capable of controlling bacteria such as *Escherichia coli*, *Pseudomonas*, *Aerobacter aerogenes* and *Alcaligenes*.

SIMPLICITY

ENSTAPH laundry compounds are completely built, ready to use in the wash wheel. No special additives or procedures are required. They provide superior soil removal and do not interfere with normal bleaching or souring operations.

RESIDUAL ACTION

The anti-bacterial system in ENSTAPH is substantive to fabric. It is activated when the linens are moistened, thereby giving true "in-use" protection against bacterial growth. The system remains effective after autoclaving and after prolonged periods of storage.

LOW COST

The protective features of ENSTAPH cost approximately 2¢ to 3¢ more per hundred pounds of dry fabric—or about 3/10¢ to 3/10¢ per bed. With the protection provided at this cost, can the hospital afford not to use ENSTAPH?

* * *

Your nearby Swift Soap Specialist will be pleased to discuss your requirements with you. He will show you a simple, fast way for your laboratory to measure the effectiveness of ENSTAPH-washed fabric. Also, ask him for the results of an in-use diaper study conducted recently at five Chicago area hospitals. If you prefer, write for details.

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106TH YEAR

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ENSTAPH, ENSTAPH CW and ENSTAPH HD complete anti-bacterial laundry compounds

LEXARD anti-bacterial bar and liquid concentrate soap for personnel and patients

LEXARD CONCENTRATE SR for surgical and pre-operative scrubbing

HERCULES CONCENTRATE KB Liquid Detergent with powerful germicide for general cleaning

13-15 ***Association of American Medical Colleges,*** Montreal, Quebec, Canada (Queen Elizabeth Hotel)

13-17 ***American Public Health Association,*** Detroit (Cobo Hall)

13-17 **Hospital Housekeeping (Advanced),** Chicago (AHA Headquarters)

13-17 **Dietary Department Administration,** Boston (Somerset Hotel)

14-16 **Directors of Hospital Volunteers (Basic),** Denver (Cosmopolitan Hotel)

26-Dec. 1 ***Radiological Society of North America,*** Chicago (Palmer House)

27-30 **Operating Room Administration (Advanced),** Indianapolis (Sheraton-Lincoln Hotel)

28-30 **Hospital Dental Service (Advanced),** Chicago (AHA Headquarters)

30-Dec. 1 Illinois Hospital Association, Springfield (St. Nicholas Hotel)

DECEMBER

11-15 **Hospital Design and Construction,** Los Angeles (Statler Hilton)

13-15 **Medical Record Librarian's Institute on Medical-Legal-Principles of Medical Record Administration (Advanced),** Chicago (AHA Headquarters)

26-31 ***American Association for the Advancement of Science,*** Denver (Denver Hilton)

JANUARY

8-12 **Dietary Department Administration,** Pittsburgh

17-19 Alabama Hospital Association, Mobile (Admiral Semmes Hotel)

22-24 **National Association of Private Psychiatric Hospitals,** Sarasota, Fla. (Colony Beach Resort)

22-26 **Nursing Service Administration,** Memphis, Tenn.

26 South Carolina Hospital Association, Columbia (Wade Hampton Hotel)

31-Feb. 1 **American Hospital Association Midyear Conference of Presidents and Secretaries,** Chicago (AHA Headquarters)

FEBRUARY

1-3 ***American College of Hospital Administrators Congress on Administration,*** Chicago (Morrison Hotel)

5-9 **Nursing Service Administration,** San Francisco

5-9 **Special Institute for Medical Record Librarians on Organization and Management,** Chicago (AHA Headquarters)

12-14 **Budgeting,** Chicago (AHA Headquarters)

19-21 **Personnel Administration (Advanced),** Louisville, Ky.

26-March 2 ***American Protestant Hospital Association,*** Chicago

MARCH

5-8 **Emergency Room Nursing Service Management,** Chicago (AHA Headquarters)

12-14 **Directors of Hospital Volunteers (Advanced),** Chicago (AHA Headquarters)

13-16 **Hospital Purchasing (Advanced),** Baton Rouge, La.

14-16 Louisiana Hospital Association, Baton Rouge (Capitol House Hotel)

15 Wisconsin Hospital Association, Milwaukee (Schroeder Hotel)

19-21 **Labor Relations,** Chicago (AHA Headquarters)

20-22 Kentucky Hospital Association, Louisville (Kentucky Hotel)

26-28 New England Hospital Assembly, Boston (Statler-Hilton Hotel)

26-29 **Evening and Night Nursing Service Administration,** Chicago (AHA Headquarters)

27-30 **Nursing Home Administration,** Miami Beach, Fla.

When scrubbing your floors

—shave off dirty wax without gouging

The tough, but springy, steel wool fibers in Brillo Floor Pads shave imbedded dirt . . . without the scratching action of the grit in abradant nylon pads that can gouge through the old wax and groove the floor itself.

A Brillo Steel Wool Floor Pad used with a good liquid cleaner will do the best possible scrubbing job—removing old wax and dirt—without scratching.

And solid disc pads cover the *entire* working surface to do the job faster.

There's a Brillo Solid Disc Steel Wool Floor Pad for every job . . . scrubbing, dry-cleaning or buffing. Send for free instructive folder today.

To strip floors completely
Use BRILLO Syndisc®
REVERSIBLE FLOOR PADS

BRILLO®

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STEEL WOOL

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BRILLO FLOOR PADS—*The Safe Way to Beautiful Floors*

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not a general-purpose antibiotic

Albamycin is not a broad-spectrum antibiotic, recommended for routine infections. It is specific for staphylococci (including resistant strains), and its use alone should (with the exceptions listed below) be limited to those cases in which staph is known or strongly suspected to be the causative organism.

Albamycin*

Indications — Albamycin is indicated in the treatment of staphylococcic infections, particularly in patients sensitive to other antibiotics or in the infections in which the organism is resistant to other antibiotics and sensitive to Albamycin, and in urinary tract infections due to microorganisms resistant to other commonly employed antibacterial agents but sensitive to Albamycin — notably certain strains of Proteus.

Administration and Dosage — Capsules and Syrup: The recommended dosage in adults is 500 mg. every twelve hours or 250 mg. every six hours, continued for at least forty-eight hours after the temperature has returned to normal and all evidence of infection has disappeared. In severe or unusually resistant infections, 0.5 Gm. every six hours or 1 Gm. every twelve hours may be employed. The dose for children is 15 mg. per kilogram of body weight per day for moderately acute infections; this may be increased to 30 to 45 mg. per kilogram of body weight per day for severe infections. These doses may be administered on schedules similar to those for adults.

Parenteral: Intramuscularly — 5 cc. of Albamycin solution may be used directly by slow injection deep into the gluteal muscle. **Intravenously** — it is recommended that 5 cc. of Albamycin solution be diluted further with 250 to 1000 cc. of sterile injection solution of sodium chloride, Darrow's solution, or Ringer's solution and administered by intravenous infusion, or by diluting to a suitable quantity and administered by continuous drip infusion. **Do not use with dextrose solution.** When it is necessary to use a smaller volume intravenously, 5 cc. of Albamycin solution may be diluted to a minimum of 30 cc. with one of the above diluents and administered slowly over a period of five to ten minutes to avoid irritation of the vascular endothelium. The dosage for adults is 500 mg. Albamycin administered either intramuscularly or intravenously every twelve hours. For children with moderately acute infections, the dosage is 15 mg. per kilogram of body weight per day. The daily dosage should be administered in two divided doses at intervals of twelve hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

Side Effects — Albamycin is a substance of low toxicity but is capable of inducing urticaria and maculopapular dermatitis. Leukopenia, which was rapidly reversible, has been reported in approximately 1% of cases. All of these side effects disappear rapidly upon discontinuance of the drug. In a certain few patients, a yellow pigment has been found in the plasma. This pigment is a metabolic by-product of the drug which, however, may interfere with determination of bilirubin and icteric index. Its presence is not associated with abnormal liver function tests or liver enlargement.

Available — Albamycin, 500 mg., sterile, Mix-O-Vial.† Each Mix-O-Vial contains: 500 mg. Novobiocin (as novobiocin sodium), also 175 mg. Nicotinamide; 0.47 cc. N,N-Dimethylacetamide; 42.3 mg. Benzyl alcohol; 4.23 cc. water for injection. Albamycin Capsules. Each capsule contains: 250 mg. Novobiocin (as novobiocin sodium). Albamycin Syrup. 125 mg. per 5 cc. Each 5 cc. (one teaspoonful) contains: 125 mg. Novobiocin (as novobiocin calcium). Preserved with methylparaben, 0.075%, and propylparaben, 0.025%.

*Trademark, Reg. U. S. Pat. Off. — The Upjohn brand of crystalline novobiocin sodium. †Trademark, Reg. U. S. Pat. Off.

The Upjohn Company
Kalamazoo, Michigan

Upjohn

Armour and Company
announces a truly effective
germicide cleaner

ARMOSOL®

In extensive laboratory tests
against eight leading brands,
Armosol® out-cleans the best
cleaner, out-kills the best
germicide!

Armosol, the result of four years of exhaustive research, is a liquid synthetic cleaner and disinfectant that kills bacteria and deodorizes as it cleans. Armosol is particularly designed for hospital and institutional use where bacterial and fungal control are of prime concern.

Eight nationally advertised products of the Armosol type were thoroughly tested and compared with Armosol. The best *cleaner* of these fell far short of Armosol's efficiency. The best *germicide* was considerably less effective.

How it is used:

Armosol effectively cleans, sanitizes and deodorizes using the ordinary cleaning techniques, sponge, mop, floor machine, spray or flood. Armosol is also useful for cleaning refrigerators, stoves and other equipment as well as in the preliminary cleaning of surgical instruments.

It is economical:

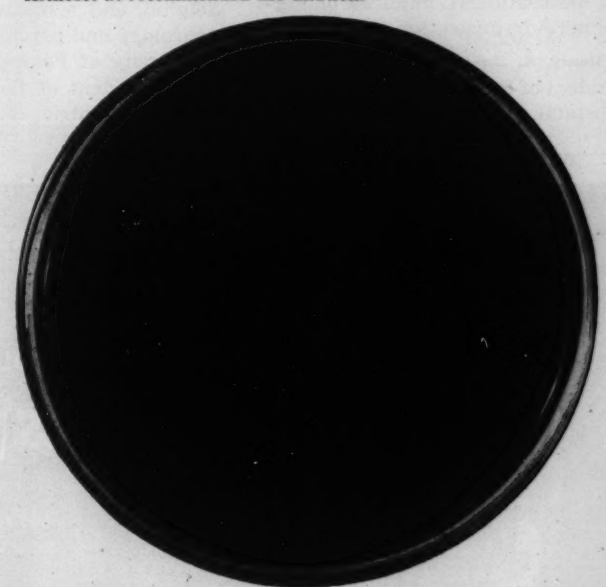
Armosol is odorless, readily soluble in both hard and soft water, non-staining, and is gentle to hands. It does three jobs at once—cleans, sanitizes and deodorizes. At the recommended concentration of 1½ ounces per one gallon of water, Armosol will clean and sanitize approximately 1500 square feet of surface. One gallon of Armosol makes 85.3 gallons of solution, or enough to clean about 127,950 square feet at an average cost per day of 1¼¢ per patient.

Environmental Sepsis Control:

Armosol, together with Dial Bar, Dial (Hexachlorophene) Surgical Liquid Soap, and Velva-Soft-G (anti-bacterial fabric finish) for all laundered linens, now helps provide a practical program for environmental sepsis control in hospitals and institutions.

For technical information please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.

"In vitro" tests demonstrate Armosol's extraordinary effectiveness. The untreated plate above shows profusely growing Staphyloccus before treatment. The second plate clearly shows the complete inhibition of growth of S. aureus after application of Armosol at recommended use dilution.



Phenol coefficient: Using the A.O.A.C. Phenol Coefficient Method (revised—1955) Armosol has a guaranteed minimum rating of 14 against *S. typhosa* and 25+ against *S. aureus*. Although newer tests have revealed that the phenol coefficient alone is not an adequate criterion of disinfection, Armosol's rating is superior to any of the eight leading similar products.

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introducing the authors

Richard W. Blaisdell, administrator of the Peninsula Hospital, Burlingame, Calif., discusses the advantages of creating a separate medical staff office with secretary in his article beginning on page 55.

Mr. Blaisdell, a graduate of the University of Minnesota Program in Hospital Administration, has been associated with Peninsula Hospital since 1952. Prior to that he was assistant administrator of the University of California Hospitals, San Francisco, for two years. Mr. Blaisdell is past president of the San Mateo County (Calif.) Visiting Nurse Association, a preceptor in the Course in Hospital Administration of the University of California, Berkeley, and a member of the American Hospital Association's Committee on Personnel Administration.

Henry A. Davidson, M.D., superintendent of Essex County Overbrook Hospital, Cedar Grove, N.J., in his article beginning on page 59, lists and discusses the 10-easy-to-follow steps to executive failure.

DR. DAVIDSON

Dr. Davidson, who is also the editor of the New Jersey State Medical Journal, as well as a lecturer at the School of Public Health and Hospital Administration, Columbia University, and the author of four books and more than 50 professional and scientific articles, received his medical degree from Jefferson Medical College, Philadelphia, and a master's degree in neurology and psychiatry from the University of Pennsylvania. He is past president of the New Jersey Neuropsychiatric Association and fellow and parliamentarian of the American Psychiatric Association.

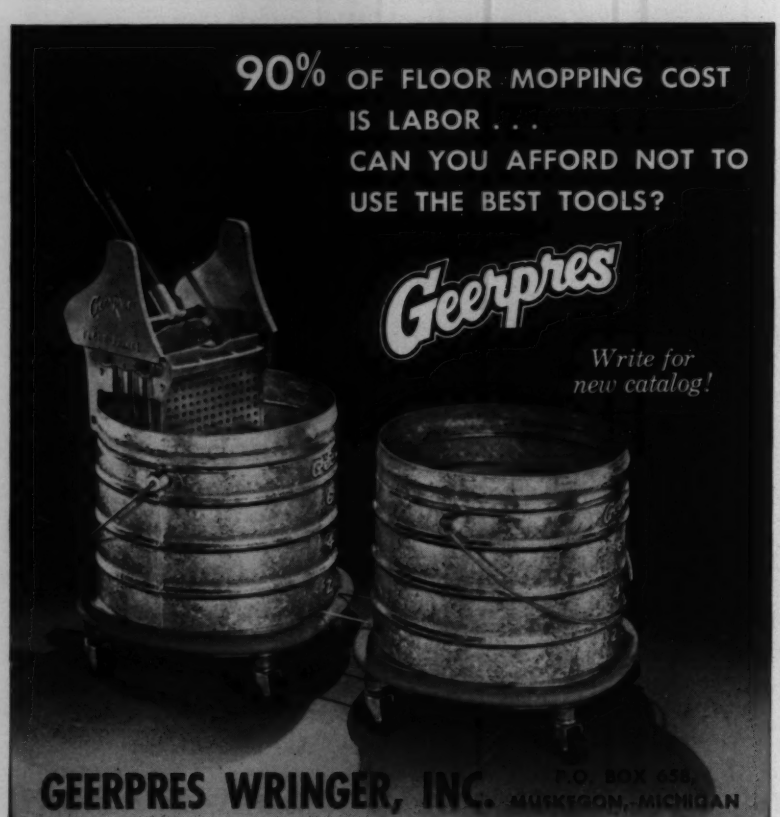
Robert P. Fischelis, Phar.D., Sc.D., discusses the contemporary hospital pharmacy in his article beginning on page 75. This is the first of three articles on the subject, which will appear in this Journal.

Dr. Fischelis, who is past president of the American Pharmaceutical Association and who retired as secretary and general manager of the association in 1959, is now a consultant in pharmacy to various nonprofit organizations and to federal and state governmental agencies. He has also served as Dean of the College of Pharmacy, Rutgers University, and as secretary and chief chemist of the New Jersey State Board of Pharmacy. During World War II, Dr. Fischelis organized and served as director of the division of chemicals, drugs and health supplies of the Office of Civilian Requirements, War Production Board. Dr. Fischelis has also been an adviser to the American Delegation, International Health Conference and consultant to the surgeons-general of the Army, Navy and Public Health Service, as well as pharmacy consultant to the Bureau of Public Assistance, Social Security Administration, Department of Health, Education, and Welfare.

DR. FISCHELIS

Dr. Fischelis received his Ph.M. and Sc.D. degrees from the Philadelphia College of Pharmacy and Science, and his Ph.G., Ph.C., and Phar.D. degrees from the Medico-Chirurgical College of Philadelphia.

Dr. Fischelis, a member of many professional organizations, is past president of the New Jersey Pharmaceutical Association and the Pennsylvania Pharmaceutical Association. He has also received several honors, including the Remington Honor Medal of the American Pharmaceutical Association. ■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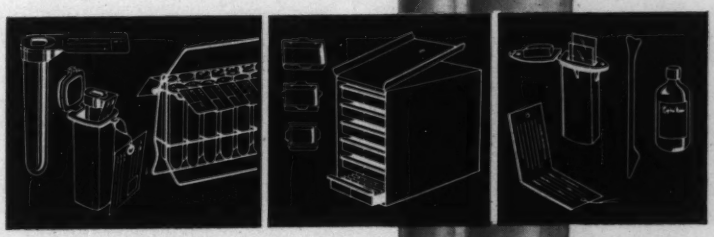

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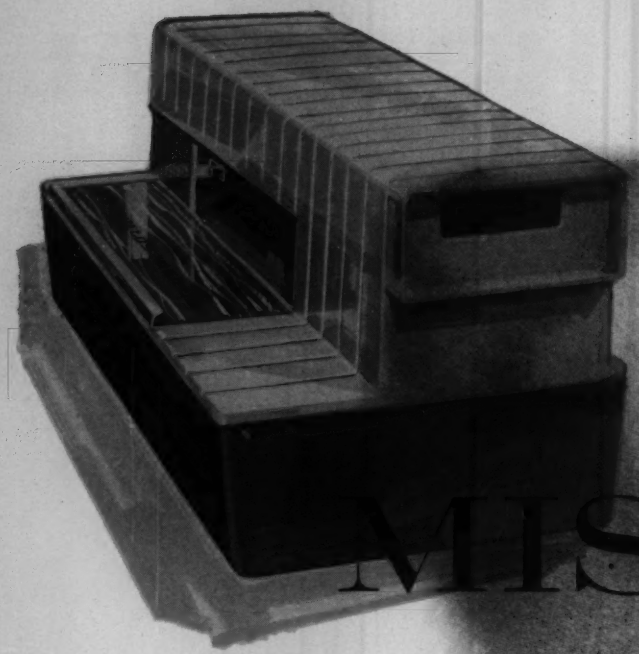

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TEXAS HOSPITALS RALLY TO AID HURRICANE CARLA VICTIMS—When Hurricane Carla roared across the Gulf Coast of Texas, hospitals within the affected 500-mile coastal area met the challenge.

The hurricane, one of the worst in history, drove hundreds of thousands of Texans from their homes along the flooded coast, and spawned death-dealing tornadoes.

Hospitals faced many problems: the evacuation of patients to inland areas; the preparation for handling possible hurricane and tornado victims; the accommodation of thousands of homeless evacuees; the continuation of good patient care despite food shortages, water pollution, electrical power failures and damage to facilities from heavy winds, rain and flooding.

Most hospitals affected by the hurricane had at least 24 hours warning—enough time to stockpile food and fresh water and to put emergency equipment into working order. *(Details p. 114)*

LACK OF COMMUNICATIONS, EMERGENCY POWER HINDERS LOUISIANA HOSPITALS—The lack of radio communications and the limited emergency electrical supply were two obstacles hindering disaster services in Louisiana hospitals when tornadoes—produced by Hurricane Carla—ravaged the state's coastal area.

According to Joseph W. Hinsley, administrator, Lake Charles Memorial Hospital, "The storm has brought greater realization" of the needs of hospitals for better radio communications systems and independent electrical generators. *(Details p. 122)*

REPORT FROM WASHINGTON—Just before Congress adjourned on September 27, it passed a supplemental appropriations bill giving added funds to the Hill-Burton program, as authorized in the Community Health Services and Facilities Act of 1961. The increase was $8.5 million for construction grants for nonprofit and publicly owned nursing homes. This brings the total appropriated for this program, in fiscal year 1962, to $18.5 million.

The total appropriation for the Hill-Burton program is $211.5 million: $150 million for Part C construction projects for hospitals and health centers; $59,728,000 for Part G construction projects for nursing homes, diagnostic and treatment centers, rehabilitation facilities and chronic disease hospitals, and $1,772,000 for administrative expenses.

- Among other provisions in the Community Health Services and Facilities Act of 1961 is a revision of the definition of "rehabilitation facility" in Hill-Burton Part G construction projects. As now stated, the term "means a facility operated for rehabilitation of disabled person through a program of medical evaluation and services, and at least one of the following programs: Psychological, social or vocational evaluation and services".
- Also in the closing days of the 1961 Congressional session, Sen. Jacob Javits (R-N.Y.) introduced a bill to amend the Hill-Burton Act to prohibit discrimination in hospital facilities. The bill (S.2625) was referred to the Senate Committee on Labor and Public Welfare. *(Details p. 110)*

CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGONS MEETS IN CHICAGO—Surgeons, physicians and medical personnel in related fields attended the 47th annual meeting of the Clinical Congress of the American College of Surgeons in Chicago, October 2-6.

Developments in every phase of surgery were represented at the five-day Congress—the largest surgical meeting in the world. According to John Paul North, M.D., director of the college, attendance was expected to reach 11,000.

Speakers at the sessions included Vice Admiral Hyman G. Rickover, United States Navy, nuclear-powered submarine pioneer and educator; Preston A. Wade, M.D., professor of surgery, Cornell University, New York, and orthopedic consultant to President John F. Kennedy, and Robert M. Zollinger, professor and head of the department of surgery, Ohio State University College of Medicine, and incoming president of the American College of Surgeons.

One of the highlights of the meeting was the groundbreaking ceremony on October 2 for the $3 million, eight-story American College of Surgeons headquarters building in Chicago. The building is scheduled for occupancy in May 1963, during the College's 50th anniversary year.

COMPUTER WILL BE USED TO ANALYZE HOSPITAL PATIENT RECORDS—The records of 2.5 million patients discharged from hospitals in 1962 will be analyzed on an electronic computer as part of an extensive project of the Commission on Professional and Hospital Activity. The commission was established in 1955, by the American Hospital Association, the American College of Surgeons, the American College of Physicians and the Southwestern Michigan Hospital Council.

The project, included under the commission's Professional Activity Study (PAS), is part of a continuing program directed toward the improvement of patient care and over-all hospital efficiency. The project is said to be the first large-scale use of an electronic data-processing system to analyze hospital records.

According to Virgil N. Slee, M.D., commission director, results of the study are designed to enable hospitals to compare their patient-to-patient performance with that of other institutions. Dr. Slee said the commission already has started analyzing the clinical records of patients from 201 hospitals which are members of PAS on a part-time basis.

N.J. BLUE CROSS-BLUE SHIELD OFFERS EXTENDED BENEFITS TO SUBSCRIBERS—A group of New Jersey Blue Cross and Blue Shield subscribers and

their dependents have been offered an expansion of available health care benefits.

On October 15, Hospital Service Plan of New Jersey (Blue Cross) and Medical-Surgical Plan of New Jersey (Blue Shield) introduced a rider to their basic contracts. When purchased at nominal extra cost, the rider provides extended benefits for certain diagnostic and therapeutic services performed either in doctors' offices or hospital outpatient departments.

Known as "Rider J", the new rider, according to the two Plans, marks the first time that the two separate health care organizations have joined to make common benefits available in a single package.

Under the new program, the services covered in the common benefits will be rendered through a hospital outpatient department, or in a doctor's office, depending on the attending physician's selection of facility. Blue Cross will make the payment on behalf of the subscriber when the services are provided by the hospital; otherwise, Blue Shield will make the payment. A subscriber will be entitled to available benefits through either Plan, or both, so long as the maximum amount payable for the service is not exceeded during a year.

Nearly two million persons enrolled through employee groups for basic coverage in both plans will be eligible to obtain "Rider J" extended coverage, provided that their group's basic enrollment percentage requirement is met and at least 75 per cent of the employees enrolled in the group purchase the rider.

Subscriber's groups may elect, at varying rates, any of four coverage periods: 22 to 70 days; 22 to 120 days; 22 to 180 days, or 22 to 265 days.

DOCTOR DRAFT MAY REACH 520—The Department of Defense reported in late September that it was planning to draft 520 doctors for the three branches of the armed services to provide adequate medical care for the increased defense forces. The figure being presented to Selective Service was reached after new volunteers and Berry Plan enrollees had been taken into account. The draft apportionment for the three services is 275 for the Army, 150 for the Air Force and 95 for the Navy.

MORE STATES ADOPT KERR-MILLS AGED MEDICAL ASSISTANCE—An HEW tally in the latter part of September reported 18 states and territories with programs in effect for the medically indigent aged under Kerr-Mills. They are: Arkansas, Hawaii, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Michigan, New York, North Dakota, Oklahoma, Puerto Rico, South Carolina, Tennessee, Utah, the Virgin Islands, Washington and West Virginia.

Three others had submitted plans to HEW, but as of September 25, had not put programs into effect. They are Louisiana and New Hampshire, planning an October 1 starting date, and Oregon, November 1. Seven others had enacted the necessary legislation to participate, but had not submitted plans to HEW. They are: Alabama, California, Connecticut, Guam, Maine, Pennsylvania and Vermont.

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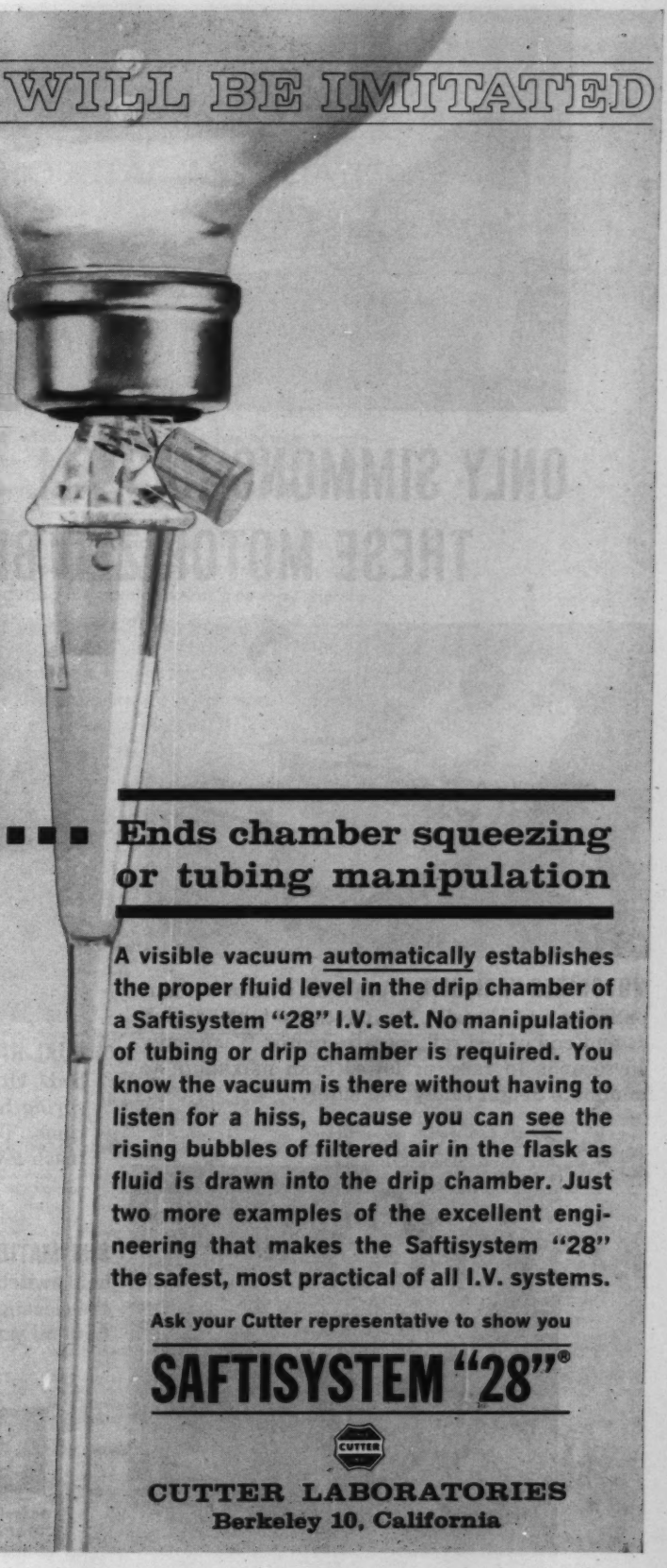

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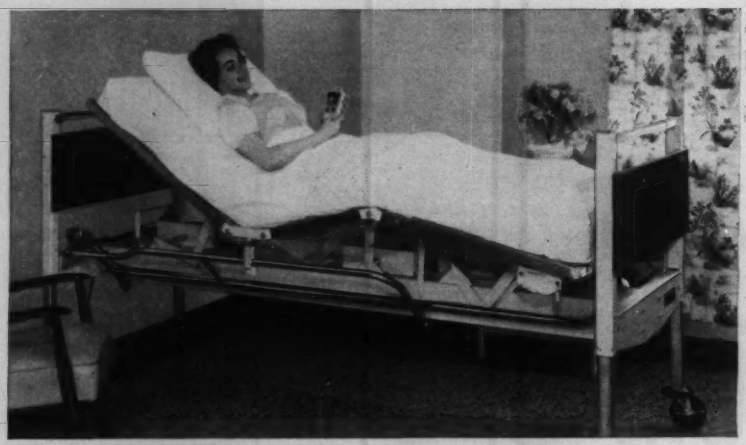

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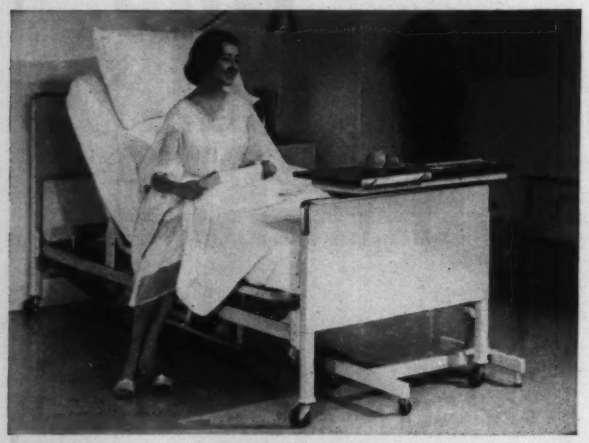

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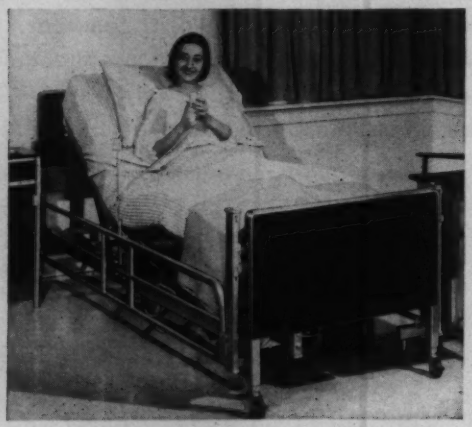

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AMERICAN HOSPITAL ASSOCIATION
DIRECTORY OF OFFICERS, COUNCILS AND COMMITTEES FOR 1962

This directory lists the officers, councils, trustees and committees of the Association for the year which began at the close of the 1961 Annual Meeting in September and which will end at the close of the 1962 Annual Meeting.

The pages of this special section have been perforated so that they may be removed from the magazine for convenient reference during the coming year. You may wish to insert this section in your copy of the August 1961 Guide Issue, Part 2.

Most of the appointments in this directory are for one-year terms. Where the appointment is for more than one year, the year of termination is shown.

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Term Expires 1963

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Henry N. Pratt, M.D., Society of the New York Hospital, 525 E. 68th St., New York 21
Kenneth Williamson, Washington Service Bureau, Mills Bldg., 17th St. and Pennsylvania Ave., N.W., Washington 6

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Term Expires 1963

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John M. Danielson, Evanston Hospital, 2650 Ridge Ave., Evanston, Ill.
Jack A. L. Hahn *(vice chairman)*, Methodist Hospital of Indiana, 1604 N. Capitol Ave., Indianapolis 7

Term Expires 1964

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Walter J. Rome, Children's Hospital of Pittsburgh, 125 De Soto St., Pittsburgh 13
John M. Stacey, University of Virginia Hospital, Charlottesville, Va.
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William Bartley, Richmond Memorial Hospital, 1300 Westwood Ave., Richmond 27, Va.
Kenath Hartman, Chicago Wesley Memorial Hospital, 250 E. Superior St., Chicago 11
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Brady Lee Mootz, City Memorial Hospital, Winston-Salem, N.C.
Marcus G. Myers, Parkview Memorial Hospital, Fort Wayne 3, Ind.
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Committee on Disaster Planning

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Committee on Engineering and Maintenance

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Philip Dreifuss, Menorah Medical Center, 4949 Rockhill Rd., Kansas City 10, Mo.
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Leland J. Mamer, University Hospital-Bellevue Medical Center, 550 First Ave., New York 16
Hugh Rafferty, St. Joseph Hospital, 1910 Crawford St., Houston 2, Tex.
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Nominating Committee of Personal Membership Department for Hospital Engineers

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John A. Holbrook, 141 Poplar Ave., Elmhurst, Ill.
Leland J. Mamer, University Hospital-Bellevue Medical Center, 550 First Ave., New York 16
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Committee on Insurance for Hospitals

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Ted O. Lloyd, Missouri Hospital Association, Medical Arts Bldg., Jefferson City, Mo.
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George Gossett, Johns Hopkins Hospital, 601 N. Broadway, Baltimore 5

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CGSB Consumer Goods Standards Board
Warner S. Deyoe, University Hospital of New York University Medical Center, 303 E. 20th St., New York 3
C21 Ceramic Whitewares
Robert J. Dobson, New York City Department of Hospitals, 125 Worth St., New York 13
Z8 Safety Code for Laundry and Dry Cleaning Machinery and Operations
Ethel Downey, Miami Valley Hospital, 1 Wyoming St., Dayton 9, Ohio
B38 Standards for Household Refrigerators and Home and Farm Freezers
Joan Evans, Westmoreland Hospital, 532 W. Pittsburgh, Greensburg, Pa.
Z50 Safety Code for Bakery Equipment
Mrs. Katherine E. Flack, Department of Mental Hygiene, State of New York, 240 State St., Albany 1, N.Y.
L17 Women's Occupational Clothing
Z64 Mass Feeding Kitchen Utensils and Containers
Ernest F. W. Franck, R.F.D., Roslyn, N.Y.
A40.8 National Plumbing Code
Edgar L. Geibel, Stamford Hospital, 190 W. Broad St., Stamford, Conn. (Madison B. Brown, M.D., alternate)
176 U.S.A. Committee for ISO/TC 76 Transfusion Equipment for Medical Use
Z79 Standards for Anesthetic Equipment
George Gossett, Johns Hopkins Hospital, 601 N. Broadway, Baltimore 5
L14 Textile Test Methods
L24 Institutional Textiles
Raymond H. Layer, Hospital Bureau, Inc., 60 W. 55th St., New York 19
L22 Textiles
Roger C. Mellem, 840 North Lake Shore Drive, Chicago 11 (G. A. Weidemier, alternate)
A9 Building Exits Code
Z65 Building Areas
Margaret E. Peters, Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16
A117 Facilities in Public Buildings for Persons with Physical Handicaps
Cornelia C. Pratt, Hospital Center at Orange, 118 S. Essex Ave., Orange, N.J.
L12 Standards for Bedding and Upholstery
Peter B. Terenzio, Roosevelt Hospital, 428 W. 59th St., New York 19
Z66 Prevention or Control of Hazards to Children
James G. Terrill Jr., Division of Radiological Health, U.S. Public Health Service, Washington 25
N6 Reactor Safety Standards
George J. Thomas, M.D., St. Francis General Hospital and Rehabilitation Center, 408 45th St., Pittsburgh 1 (Madison B. Brown, M.D., alternate)
Z79 Standards for Anesthetic Equipment

Representatives to Committees of U.S. Department of Commerce

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CS146-47 Gowns for Hospital Patients
Jason P. Blake, Michael Reese Hospital, 2839 S. Ellis Ave., Chicago 16
R85 Adhesive Plaster
Franklin D. Carr, Detroit Memorial Hospital, 1420 St. Antoine St., Detroit 26
R249 Plastic Tableware
Paul E. Cash, Kentucky Baptist Hospital, 810 Barret Ave., Louisville 4, Ky.
R86 Surgical Gauze
R133 Surgical Dressings
Eugene M. Dawson, Department of Mental Hygiene and Correction, 65 S. Front St., Columbus 15, Ohio (Roger C. Mellem, alternate)
TX-5385 Casters, Wheels and Glides for Hospital Equipment
Roger W. DeBusk, M.D., Grace Hospital, 4160 John R. St., Detroit 1
CS37-31 Steel Bone Plates and Screws
Mrs. Elizabeth C. Downes, Mountainside Hospital, Bay & Highland Aves., Montclair, N.J.
K63 Subcommittee I—Hand and Dishwashing Compounds
Anthony W. Eckert, Perth Amboy General Hospital, 530 New Brunswick Ave., Perth Amboy, N.J.
ISO/TC75 Conference on Stretchers and Stretcher Carriers
Roald B. Gleshe, Methodist Hospital of Gary, 1600 W. 6th Ave., Gary, Ind. (Roger C. Mellem, alternate)
R106 Hospital Plumbing Fixtures
CS20-49 Vitreous China Plumbing Fixtures
Vincent W. Godlesky, Beth Israel Hospital, 330 Brookline Ave., Boston 15
CS1-52 Clinical Thermometers
Reuben H. Graham, North Carolina Baptist Hospital, 300 S. Hawthorne Rd., Winston-Salem 7, N.C.
R-24 Hospital Beds
CS54-36 Mattresses for Hospitals
CS55-36 Mattresses for Institutions
CS182-51 Latex Foam Mattresses for Hospitals
Raymond H. Layer, Hospital Bureau, Inc., 60 W. 55th St., New York 19
R-74 Hospital and Institutional Cotton Textiles
K-63 Subcommittee II—Metal Polishing Products
Leland J. Mamer, University Hospital-Bellevue Medical Center, 550 1st Ave., New York 16
K63 Minimum Performance Standards for Institutional Cleaning and Maintenance Supplies
Subcommittee II—Surface Cleaning Products
Subcommittee IV—Floor and Furniture Polishing Products
Col. Allen Papoas, MSC, Brooke Army Medical Center, Fort Sam Houston, Tex.
R176 Color Marking for Anesthetic Gas Cylinders
Harold A. Schneider, Maimonides Hospital, 4802 10th Ave., Brooklyn 19, N.Y.
R224 Medical and Surgical Hypodermic Needles (Hospital Use)
Z70 Conference and Hypodermic Syringes and Needles
ISO/TC 84 Syringes and Needles
Bernhard Steinberg, M.D., Toledo Hospital, N. Cove Blvd., Toledo 6, Ohio
ISO/TC 48 Laboratory Glassware and Related Apparatus
Lloyd L. Sundquist, Procurement Section, National Institutes of Health, Bethesda 14, Md.
R240 Clinical Utensils, Aluminum, Enameled Steel and Stainless Steel
J. Hasbrouck Wallace, Grace-New Haven Community Hospital, 789 Howard Ave., New Haven 4, Conn.
R239 Surgical Sutures
CS136-46 Blankets for Hospitals
Paul E. Widman, Cleveland Clinic Hospital, 2050 E. 93rd St., Cleveland 6
R40 Hospital Chinaware
CS38-32 Hospital Rubber Sheeting
CS40-32 Surgeons Rubber Gloves
CS41-32 Surgeons Latex Gloves
CS114-43 Hospital Sheeting for Mattress Protection

COUNCIL ON ASSOCIATION SERVICES

Chairman: John A. Dare, Virginia Mason Hospital, 1111 Terry Ave., Seattle 1

Term Expires 1962

William S. Brines *(vice chairman)*, Newton-Wellesley Hospital, Newton Lower Falls 62, Mass.
J. A. Gilbreath, Arkansas Baptist Hospital, 1700 W. 13th St., Little Rock
Richard Lubben, Kadlec Methodist Hospital, 1005 Guthrie St., Richland, Wash.

Term Expires 1963

Gene Kidd, Baptist Hospital, 200 Church St., Nashville 4, Tenn.
Stuart W. Knox, Connecticut Hospital Association, 160 St. Ronan St., New Haven 11, Conn.
Benjamin W. Wright, Executive Vice President of the Orange Memorial Hospital, 188 South Essex Ave., Orange, New Jersey

Term Expires 1964

Sister Eugene Marie, Good Samaritan Hospital, 3217 Clifton Ave., Cincinnati 20
C. Franklin Fielden Jr., Memorial Hospital, 1400 E. Boulder St., Colorado Springs, Colo.
One Vacancy

Secretary: Jack W. Owen, 840 North Lake Shore Drive, Chicago 11

Committee on Hospital Governing Boards

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Roger DeBusk, M.D., Grace Hospital, 4160 John R. St., Detroit 1
Edison Dick (Address: 919 N. Michigan Ave., Chicago 11) Passavant Memorial Hospital
Rev. John J. Flanagan, S.J., Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis 4
Robert J. Koshland (Address: 217 W. Santa Inez, Hillsborough, Calif.) Peninsula Hospital, Burlingame, Calif.
W. Douglas Piercey, M.D., Canadian Hospital Association, 25 Imperial St., Toronto 7, Ont.
Charles B. Wade Jr. (Address: Reynolds Tobacco Co., Winston-Salem, N.C.) City Memorial Hospital

Committee on Metropolitan Hospital Associations

Chairman: Donald E. Wood, Twin City Regional Hospital Council, 2610 University Ave., St. Paul 14
Henry G. Brickman, Massachusetts Hospital Association, 14 Somerset St., Boston 8
Howard F. Cook, Chicago Hospital Council, 840 North Lake Shore Dr., Chicago 11
William R. Huff, Carolinas-Virginias Hospital Conference, 316 Morrison Bldg., Charleston 1, W.Va.
Mrs. Ruth F. McLean, Nassau-Suffolk Hospital Council, 320 Old Country Rd., Garden City, L.I., N.Y.
E. W. Miller, Huron Road Hospital, 13951 Terrace Rd., Cleveland 12
Jerry N. Ransohoff, Greater Cincinnati Hospital Council, 2212 Victory Pkwy., Cincinnati 6

Committee on Program for Hospital Chaplains

Chairman: Rev. Granger Westberg, University of Chicago Clinics, 950 E. 59th St., Chicago 37
Sister Eugene Marie, Good Samaritan Hospital, 3217 Clifton Ave., Cincinnati 20
Leo M. Lyons, American Protestant Hospital Association, 840 North Lake Shore Dr., Chicago 11
Rabbi Irvin M. Melamed, Chicago Board of Rabbis, 72 E. 11th St., Chicago 5

Committee on Regional Hospital Associations

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Albion K. Parris, Maryland-District of Columbia-Delaware Hospital Association, 406 Keyser Bldg., Baltimore 2
Melvin C. Scheflin, Association of Western Hospitals, 26 O'Farrell St., San Francisco 8

Glen Taylor, Upper Midwest Hospital Conference, 410 Church St., S.E., Minneapolis 14
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Committee on State Hospital Associations

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William R. Huff, Carolinas-Virginias Hospital Conference, 316 Morrison Bldg., Charleston 1, W.Va.
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COUNCIL ON BLUE CROSS, FINANCING AND PREPAYMENT

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Committee on Standards and Evaluation

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Riley McDavid, Kenosha Hospital, Kenosha, Wis.
Clarence E. Wonnacott *(vice chairman)*, Latter-day Saints Hospital, 325 8th Ave., Salt Lake City 3, Utah

Term Expires 1963

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James P. Richardson, Presbyterian Hospital, Box 10157, Charlotte 1, N.C.

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Karl K. Schmidt Jr., National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12
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Peter A. Volpe, M.D., University Hospital, Ohio State University, Columbus 10, Ohio

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National Health Council

Committee on Health Education

Daniel S. Schechter, 840 North Lake Shore Drive, Chicago 11

Committee on Research

Dean A. Clark, M.D., Massachusetts General Hospital, Fruit St., Boston 14

Committee on State and Local Health Councils

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National Advisory Committee on Local Health Departments

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National Society for Medical Research

Steering Committee

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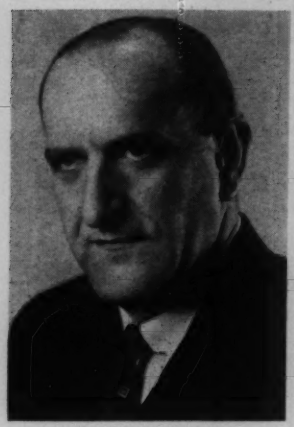

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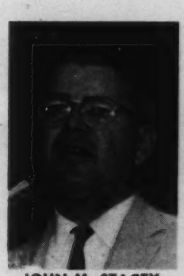

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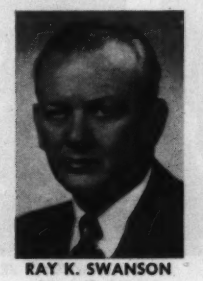

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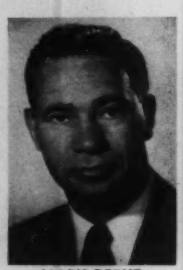

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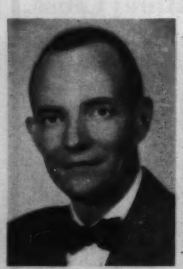

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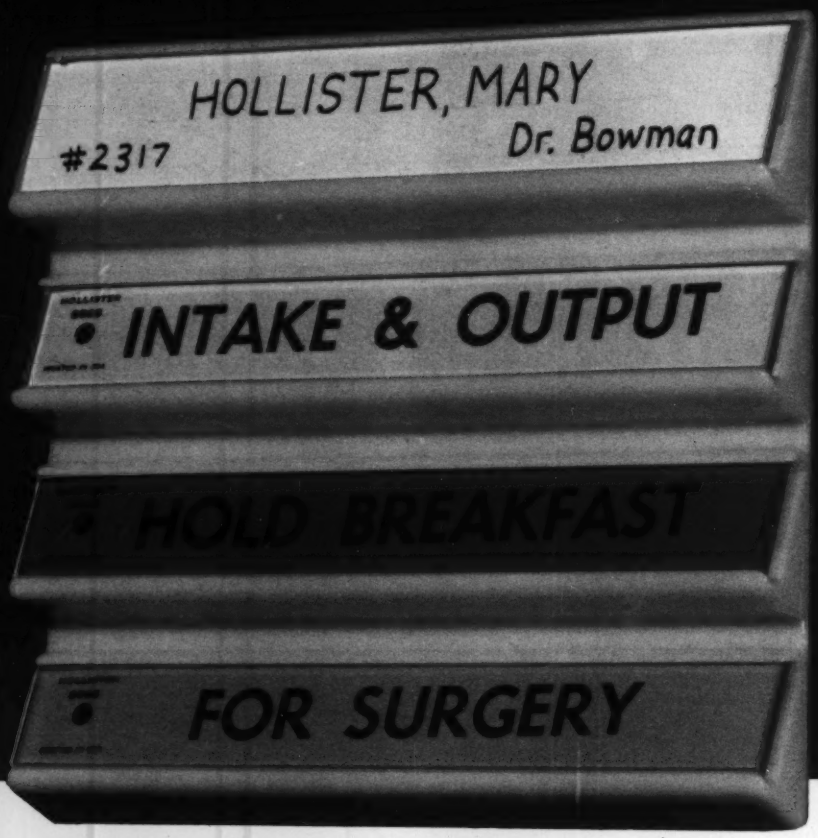

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accreditation problems

- infection committee
- need to review all cases
- 'single' transfusions
- number of cases at staff meetings
- drug and clinical orders
- dilatation and curettage

KENNETH B. BABCOCK, M.D.

Why do we have to have an infection committee? We have had practically no infections over the years.

The best answer to your question is a quotation from a recent article on hospital infections: "A sudden outbreak of infection emphasizes the fact that inadequate protection against hospital infections may continue for many years until the arrival of an especially dangerous organism reveals the defects in protective arrangements. Such an outbreak reminds us that freedom from serious trouble cannot rightfully be used to justify neglect in applying proven methods of precaution."

* * *

Ours is a teaching hospital with approximately 80 per cent service cases and 20 per cent private cases. Should only the service cases be reviewed, as our doctors contend, or should both types of cases be reviewed?

All cases should be reviewed. Frankly, if they are not, you could possibly be accused of a double standard of care. Your hospital bylaws should read: "The medical staff is responsible for the quality of all medical care rendered to patients in the hospital."

Likewise, in departmentalized hospitals, the head of a department is expected to have general supervision of the clinical work done in the department, whether it be "service" or "private".

* * *

How can the Joint Commission condemn (1) "single" transfusions and (2) tonsillectomies from a distance, on the basis of statistics alone?

We don't—nobody should. We do ask that hospital medical staffs carefully study the above two operations in their own hospitals and justify them on the basis of need by proven medical standards. The Joint Commission does not practice medicine, but we would like you to be able to prove the justification of these procedures to your satisfaction and ours.

* * *

Our doctors resent the requirement that four or five cases should be presented at staff meetings. They would rather have one or two longer cases. They say the short cases are presented at departmental meetings.

There is no such requirement by the Joint Commission as mentioned above. We do want good review of hospital cases. I agree with your doctors. One or two good cases of general interest, well presented and discussed, are far better than four or five superficially presented. We look for quality, not quantity.

* * *

Can our telephone operator take drug and clinical orders for the patient's care when the nurses are busy, then later transmit them to the nurses?

No. She should not be allowed to do this. The phone order by itself is bad enough and should be used sparingly. Drug and clinical orders should be given only to a registered nurse.

* * *

Does the Joint Commission believe that it is good medical practice to perform dilatation and curettage in the emergency room?

No, except in emergencies and under extenuating circumstances. This procedure should be performed in the regular operating rooms. It is not good practice to perform it in the emergency room.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 200 E. Ohio St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

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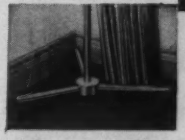

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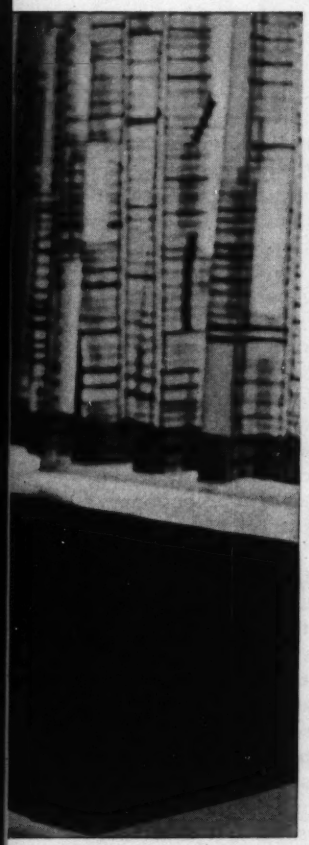
ADMINISTRATORS LIKE TUBEX. The TUBEX system means more accurate accounting and billing. Only one purchase entry required as there are no multidoses to divide. A single purchase order for cartridges simplifies buying. Inventory control is easier; medication is ordered, dispensed and accounted for in multiples of single doses. Because exact amount of medication is always known, billing to patients is more accurate.

PHARMACISTS LIKE TUBEX. Easier, more convenient storage of TUBEX units recommends this system over the usual ampuls and multidose vials. Clear labeling and accurate inventorying of single-dose units result in more efficient filling of prescriptions and less chance for error; tamper-proof cartridges discourage narcotics pilferage.

NURSES LIKE TUBEX. No time is lost in assembling syringes, sponging vials, measuring doses, rinsing syringes and needles. No clean-up problem: cartridge and needle are discarded after injection. The familiar frustrations, syringe breakage and plugged needles, are almost impossible with TUBEX. An added benefit: no multidoses to divide, no drugs spilled and no contact sensitization. Patients appreciate the relatively painless sharp, new needles.



M.D.'s LIKE TUBEX. Accurate dosage and asepsis are major benefits. Each presterilized needle-unit contains premeasured amount of medication. The TUBEX sterile cartridge-needle unit is used but once and cannot transmit cross infections (serum hepatitis).

service from headquarters

Dental surgery

Who is responsible for the preoperative medical survey and medical care aspects of a patient admitted for dental surgery? Is it feasible to have a separate dental staff in a hospital doing a large volume of dental surgery?

With regard to the preoperative medical survey and medical care of dental patients, a physician on the staff of a hospital must be responsible not only for the medical survey of a patient admitted for dental surgery, but also for all *medical* aspects of the case during the patient's stay in the hospital. All activities performed and orders issued by the physician must be signed by him, but the dentist can sign for his activities and orders, including the face sheet.

Since the medical staff is responsible for the clinical activities in the hospital, it would not be possible to have separate medical and dental staffs even though the dentists were set up as a separate department. Doing this would be comparable to separating the department of surgery completely from the rest of the medical staff, which, of course, is not feasible.

—J. R. ANDERSON, M.D.

Patient care indices

Where can we obtain information on the subject of indices to quality of patient care?

In reply to your letter inquiring about sources of information on the topic of indices to quality of patient care, the following selected bibliography will suggest several sources of information on this subject.

Brown, M. B. Evaluation of patient care: reports can tell the story. TRUSTEE 13:1-5 August 1960

Colwell, A. R. and Fenn, G. K. Standards of practice of internal medicine: methods of judging its quality in hospitals. (Editorial) *Annals of Internal Medicine* 51: 821-832 October 1959

Heal, F. C. Evaluation of medical care—an internist's view. *Canadian Hospital* 37:57 March 1960

O'Malley, M. and Kossack, C. F. Statistical study of factors influencing the quality of patient care in hospitals. *American Journal of Public Health* 40:1428-November 1950

Rosenfeld, L. S. Quality of medical care in hospitals. *American Journal of Public Health* 47:856-865 July 1957

Rourke, A. J. J. Evaluating the quality of medical care. *Hospital Progress* 38:72-73 September 1957

Sheps, M. C. Approaches to the quality of hospital care. *Public Health Reports* 70:877-886 September 1955

Verda, D. J. and Platt, W. R. Tissue Committee really gets results. *Modern Hospital* 91:74-76 September 1958

Wallace, H. M. and others. Criteria for the evaluation of the quality of maternity and new-born care. *American Journal of Public Health* 42:499-507 May 1952.

Although many other titles might have been cited in this short bibliography, these were selected on the basis of comprehensiveness of study and recency of publication.

You might also contact the following groups which have done extensive studies on evaluation of quality of patient care.

Commission on Professional and Hospital Activities, Inc., First National Building, Ann Arbor, Mich.

Systems Research Group of the Engineering Experiment Station, Ohio State University, Columbus, Ohio.

These groups will undoubtedly be able to furnish a good deal of helpful information.

—HELEN YAST

Awards for auxiliaries

Our hospital auxiliary is in the process of reviewing its program of awards to members in recognition of hospital service. We would like information on the principles we should follow in our revised program.

The American Hospital Association's booklet, *Awards, Recognitions and Uniforms for Hospital Volunteers* (Rev. 1959. Free up to 10 copies), will undoubtedly be helpful to you in reviewing the awards program for auxiliary members. In it, for instance, are the requirements set forth by the Association for the award of its basic hospital volunteer service pin (the 100 hour pin). These requirements include completion within one year (365 consecutive days) of 100 hours of volunteer work in an organized volunteer department. The one year requirement does not necessarily refer to a calendar year, January 1 to December 31; it refers rather to a year's period (365 days) which might be from May 1 to April 31, depending on the "service year" as established by each auxiliary.

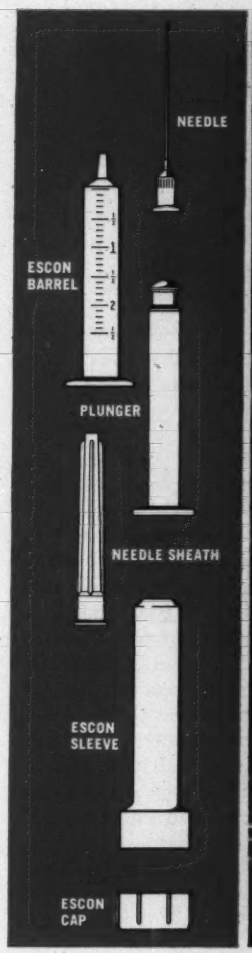
There is a similar requirement for the award of the Association's teen-age hospital volunteer pin, except that in this instance the number of hours required are 50 hours, rather than 100.

For additional hours, beyond the first 100 (or 50 for teen-agers) time is counted on a cumulative basis. Further, there is no standard by which awards are given for persons who serve less than 100 hours in any one year. However, some hospitals and their auxiliaries use the hospital auxiliary emblem as a form of award to be given at the end of a probationary term of volunteer service, usually 25 hours.

In essence, the awards program of each hospital and its auxiliary will vary, and the American Hospital Association establishes no regulations except those which are set forth in the paragraphs describing the various awards available from the Association. However, the Association does suggest strongly that awards programs should be kept as simple as possible and that they should be planned carefully to stand the test of years. Recommendations which elaborate on these two basic suggestions are included in the booklet mentioned above.

—PATRICIA SUSSMANN

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.



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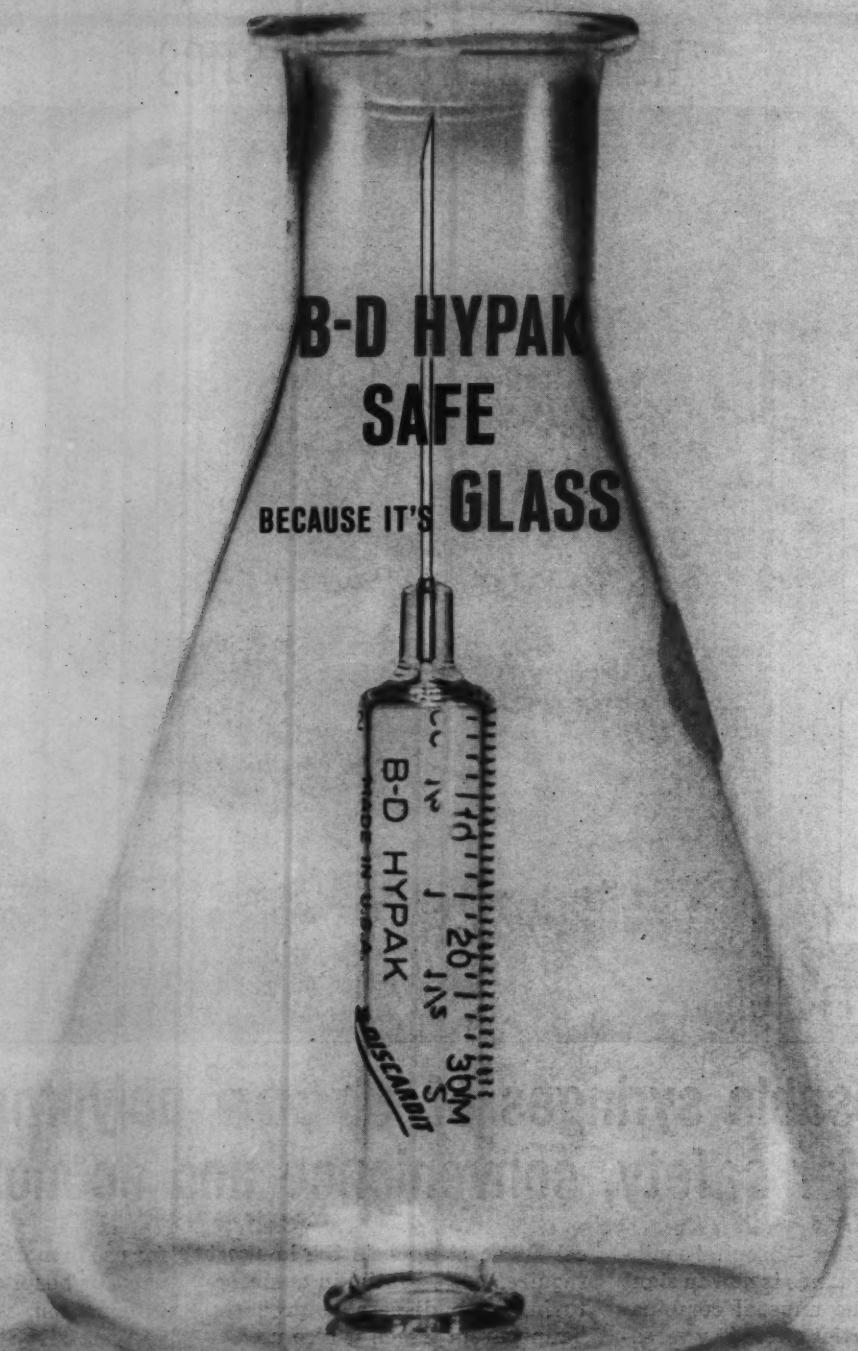

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opinions and ideas

(LEFT) Blackboard provides cooks in the kitchen of the Chicago Lying-In Hospital, University of Chicago Clinics, with up-to-the-minute information on the number of patients on different floors of the hospital and the types of diets required. (BELOW) Telephones which can be moved from one side of the bedside stand to the other were installed in patient rooms in the new wing of the Centinela Valley Community Hospital, Inglewood, Calif., with the cooperation of the telephone company.

Blackboard furnishes meal tally for cooks

Cooks busy with meal preparation in the kitchen of the Chicago Lying-In Hospital, University of Chicago Clinics, need only glance up from their tasks to see the latest figures on a blackboard of the number of patients on each floor of the hospital and the different types of diets required.

Food service is decentralized in this hospital and hot menu items are dispatched in bulk amounts by means of heated carts to the various floor pantries. Thus separate figures for each floor are needed.

An important advantage in the use of this blackboard is that the figures can be quickly changed. In fact, the figures are revised before each meal to include patients who have been admitted to the hospital since the last meal was served.

Patients in the hospital each morning receive selective menu sheets on their breakfast trays on which they can indicate their food choices for the next day. The menu sheets are tallied, and the figures for the next day are placed on the blackboard at 5 p.m. Patients on general diets who enter the hospital after the selective menus have been distributed are not given a choice, but are served what are called "first choice items".

Under the heading, "Other Specials", on this blackboard, superscripts refer to weighed or measured diets, usually diabetic diets. Thus "85^{3}" means a total of 88 diets with 3 diets weighed or measured. These weighed or measured diets are not included with the bulk food sent to various floors, but are made up on trays under the supervision of a dietitian.

Under the heading, "Employees", on this blackboard are listed the two dietary department employees on each floor who prepare the trays for patients on that floor. These employees are aided in serving foods attractively by a "tray service conference" conducted by the dietitian in the hospital kitchen just before the hot food is taken to the various floors. After all of the patients have been served, these employees eat their meals in the floor pantries. ■

Movable phone stand used in California hospital

A new type of movable telephone stand, which facilitates the sharing of a telephone by two patients, is in use in the new 60-bed wing of the Centinela Valley Community Hospital, Inglewood, Calif.

The telephone is attached to the bedside stand between two beds, and a wheel mounting permits moving the telephone from one end of the stand to the other. In addition to the advantage of movability, this telephone is elevated from the bedside stand which allows more room for the patient's personal belongings on the table. James C. Heidenreich, administrator, reports another advantage—"the problem of a falling phone has been eliminated".

This type of telephone installation has met with such favor during its use in the new wing of the hospital that it is being installed in other sections as well. ■

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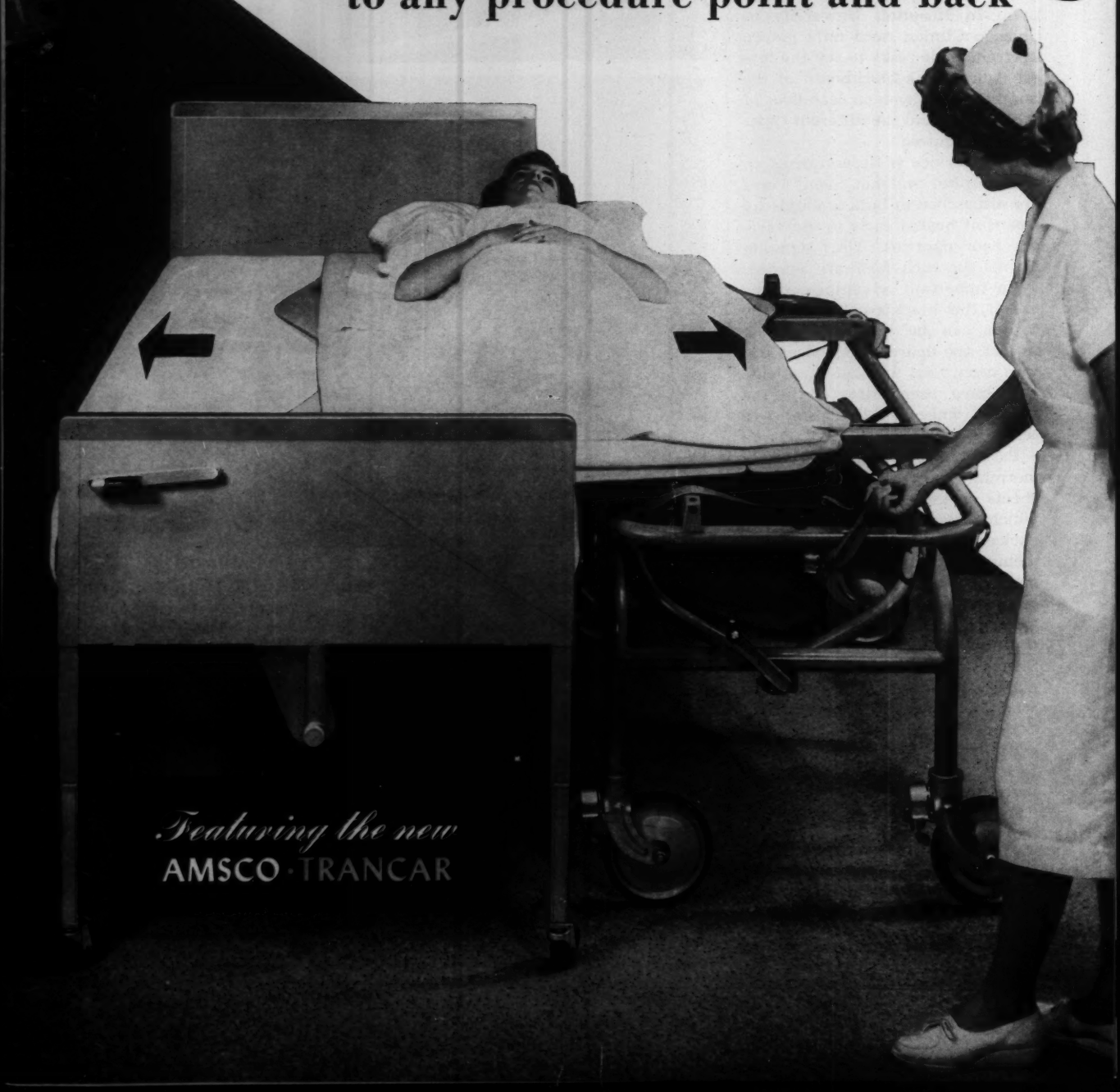

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With this revolutionary system and the patented Amsco TRANCAR, one small nurse quickly and easily transfers the most critically ill or traumatized patient from bed to operating, X-ray or treatment tables . . . *so gently the patient is scarcely aware of motion.* No longer is it necessary to gather a crew of orderlies to *lift* the patient bodily. No longer need patients suffer the pain, anxiety and trauma so often unavoidable with present handling methods.

The Amsco System is as simple as it is functional. Patients scheduled for surgery or extensive examination and treatment are placed upon a special one-inch mattress pad. The pad is comfortable, fully conductive and X-ray penetrable. The low-friction, airfoil top of the TRANCAR is cranked under the pad, fastened and returned. The pad *and* the patient are transferred horizontally *in less than two minutes.* Reversing the process places pad and patient on the operating, X-ray or treatment table, or back in bed. For the postoperative period the TRANCAR itself serves as a recovery bed, with Trendelenburg, reverse Trendelenburg and I.V. facilities.

Automatic locking devices adapt the TRANCAR to most hospital beds and to virtually all operating, treatment or examining tables. The Amsco System is adaptable to *every* hospital. It provides substantial benefits to personnel and never-before-equalled comfort and protection for critically ill patients.

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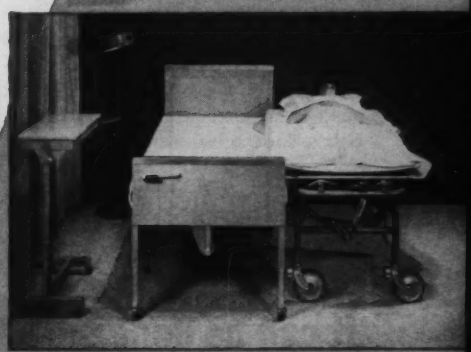

The pad is fastened and reversing the crank rotation moves the patient laterally, smoothly onto the TRANCAR.

Eight-inch, lockable casters permit easy wheeling to any treatment point in the hospital.

The patient and the conductive, X-ray penetrable pad are transferred to the Operating, Examining or Therapy Table as required. The TRANCAR itself may be used as an Operating Table for certain types of delicate eye surgery.

Postoperatively, the TRANCAR is an excellent recovery bed, with Trendelenburg, reverse Trendelenburg, and I. V. stand.

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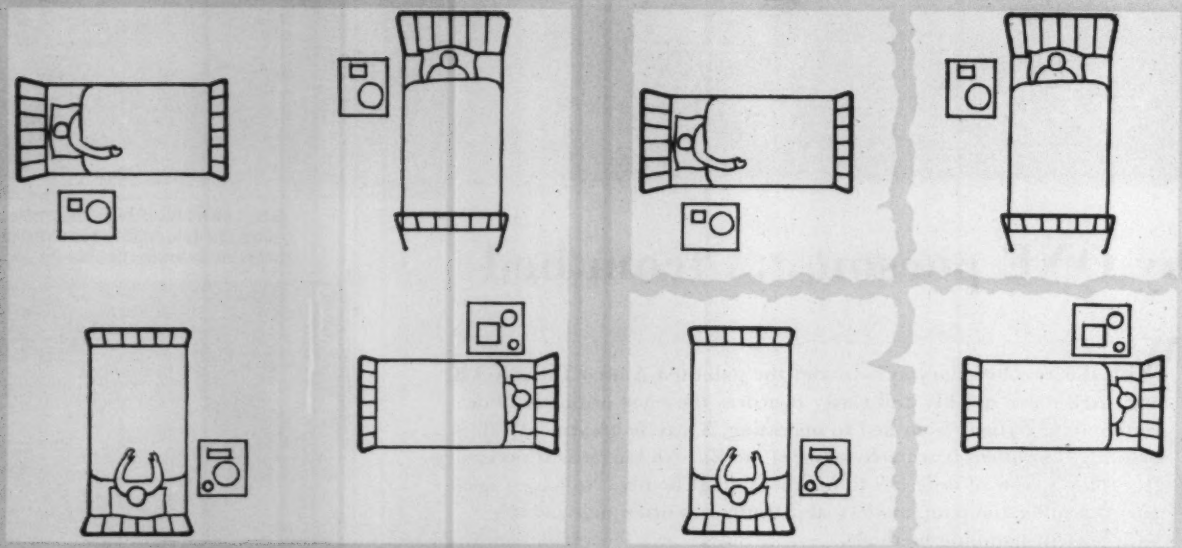

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HOSPITALS
JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION

editorial notes

—interlude for action

ONE SUBJECT which seemed certain of lengthy discussion at the 1961 annual meeting of the Association's House of Delegates was health care of the aged. The current position of the Association on this matter is the one adopted in 1958. It has been variously described as unrealistic, as fence-straddling, as comfortable fence-straddling, as much too far to the left, as one with many defects, but one which was workable during the recent years of intensive debate on the subject.

One might have expected substantial airing of the various points of view on the same subject of members of the Blue Cross Association at a special meeting called on this and other matters just before the AHA's annual meeting opened in Atlantic City.

There was little discussion in either place, but not from lack of interest. Both groups recognized the importance of this issue to hospitals, to prepayment plans, to politicians, and to the people. They also recognized two other things; that there was disagreement both from the right and the left with the identical positions of the American Hospital Association and the Blue Cross Association, and that the adjournment of the first session of the 87th Congress had removed the immediacy from the issue. It was, as the president of the Blue Cross Association, Walter J. McNerney, said, impossible that the Congress would act on the health care of the aged in the first session of the 87th Congress and while quite possible in the second session of the 87th Congress, still a matter of conjecture.

In the minds of the AHA and Blue Cross, this gave a breathing spell in which the present position could be re-examined, alternatives studied and definitive action taken on both sides within a reasonable period of time. Both groups defined "reasonable period of time" as something on the order of 90 to 120 days.

On its part, the Association has authorized a special meeting of the House of Delegates to be called as soon as possible and the Blue Cross Association is planning a special meeting of its members.

But the key point is that both the Association and the Blue Cross Association have ordered a special task force to go over the immense amount of work that has already been done and to look for new approaches, to study those things which may not have been studied, and finally to develop a policy. This policy could be reaffirmation of the present policy, it could be a compromise, or it could be something as yet unproposed.

It would be tragic if an issue of such great importance to hospitals and Prepayment Plans were decided without their significant influence. It is to be hoped, therefore, that these task forces, working in consonance, can come forward with a plan which will be acceptable to both sides, imperfect perhaps to both, but the best that can be accomplished without a serious and perhaps permanent cleavage in the ranks of those who serve the health needs of the American people and of those who make this service financially possible, the Prepayment Plans.

There is no doubt but that the actions to appoint the task forces and to call special meetings will focus attention on the final results. The action said in effect that we know that we have not been able to come with a plan acceptable to all sides and we know also that the current legislative proposals are not acceptable to all sides, but furthermore, we know that while this disagreement persists, a large group of our people are not getting the health care which we are pledged to give to them and to finance for them.

There was indeed a lack of debate on this subject, although there was some discussion on the floor of the House of Delegates. But this does not signify a shirking of responsibility. It recognizes the wisdom of deferring of the debate until another look has been taken, a look under circumstances changed since 1955 or 1958.

The development is encouraging on two major grounds. There is first the acceptance of the reality that there is no unanimity or even close to unanimity on the present proposals, and there is acceptance that a plan ought to be developed which is acceptable to all or almost all. Second, it is clearly established that in this new effort the Blue Cross Plans and the American Hospital Association, partners as they are, are going to work like partners and produce something for the partnership as a whole and for the people.

The physician and the hospital

by RUSSELL A. NELSON, M.D.

HOSPITAL-Physician Specialist relationships is a subject of particular interest to me as a hospital administrator since my early work in hospitals was as a medical student, intern, resident and teacher in internal medicine. I believe that this medical background makes it possible for me to see this problem from the point of view of the medical profession as well as of hospital management.

Everywhere in our country where one goes and talks to hospital people, there are a few items of great concern to the hospital trustees and administrators. These include: nursing school accreditation, Blue Cross, personnel procurement and, always, hospital-physician specialist relationships. We have all heard the last problem thoroughly discussed. Still, we have no satisfactory solution for all areas and all conditions. No single satisfactory agreement or operating procedure has been worked out between hospitals and physicians at a national level, and it is doubtful that this will be forthcoming at any early date.

The problem is bigger and broader than hospital-physician specialist relationships. It involves the conflicts which have arisen by the steady march of medical and surgical practice into the hospital, a march forced by the rapidly growing specialization of medicine based upon advances in the medical sciences.

We all know the signs and symptoms of the conflict—all really related to the differences arising between, on the one hand, the medical profession, and on the other, the hospital. The medical profession, by and large, approaches medicine as individual free entrepreneurs in fee-for-service practice with a minimum of administrative organization and control. The hospital is a community-based organization with an administrative mechanism progressively growing in strength and re-

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This article is adapted from a presentation given at the Association of Western Hospitals, Los Angeles, in April 1961.

It is time for a reconsideration of the relationship of the hospital and the medical staff, and high time that the medical staff should be given more responsibility and authority in the hospital, according to the author. He also recommends 11 guideposts for more effective hospital-physician cooperation, directed toward strengthening the hospital organization.

quiring rules and regulations for sensible conduct. These differences are compounded by rising costs and the necessity that the medical profession and the hospitals share the public's health dollar, and further by the fact that, by and large, hospitals are controlled by nonmedical boards and administrators. These factors obviously produce severe tensions.

Hospital boards and administrators are frustrated by the physicians' attitudes toward hospital employees and departments; by their reluctance to set medical standards and supervise or criticize each other; by a physician's occasional flagrant failure to discharge his responsibilities to the hospital in respect to emergency care, teaching, medical records and even agreed-to time schedules. At times, the physician appears to the hospital to be interested only in his problems and gives the board and administrator the impression that the hospital is run for him and not for the patients or the public.

PHYSICIANS' FRUSTRATIONS

Physicians, on the other hand, have their hospital frustrations. One of the worst is the feeling of "nagging" by hospital officials to obey rules, some of which are set without adequate medical consultation. Another is time lost because of poorly oriented and supervised employees, or inadequate equipment. Then, it seems to the physician, there is paper work and paper work and paper work. But most of all, the physician has a feeling of insecurity because he has so little control over the hospital which is so essential to his work. In this setting, we have the hospital-physician specialist conflict with emotions sharpened by the nature of the differences.

For a number of years, I have been concerned to hear some hospital administrators refer to diagnostic services in the hospital as "ancillary" services. These services are no longer ancillary—they are basic. We tend also to refer to the radiologists, pathologists and anesthesiologists as physician specialists, as if to indicate that they are in some special professional category. In fact, their only special characteristic is their financial and administrative relationship with the hospital. This attitude is part of the basic problem.

HOSPITAL USE: NOW AND THEN

In the hospital of our grandfathers' or even fathers' time, the physician was an adjunct service given on a now and then basis. In those same times, a hospital was not often used in the private practice of medicine. Today, hospital service is really medical and becoming increasingly so. Our real changes and improvements in the future will be professional and medical, not custodial. The growth in surgery and hospital obstetrics, and especially the growth in diagnostic services, make the hospital essential to the daily private practice of nearly all of our physicians.

Yet hospitals and physicians do not work as well together as they should. It is time for a reconsideration of the relationship, and high time that medical staffs be brought more closely into the hospital team, with more responsibility, more participation and more authority.

Traditionally, since the days when the physician, in return for medical services to the sick poor, was given the privilege of treating his occasional private patient in the hospital's beds, the physician has been set apart from the management of hospitals. Some of our staff titles today, such as visiting physician, attending surgeon, and the words "hospital privileges", reflect these origins and the "apartness". Within the medical staff, physicians establish their own standards of ethical, moral and scientific practice and set up their own disciplining mechanisms, as is characteristic of any good profession. But, set aside from the administrative structure of the hospital, physicians generally have focused their attention only on the medical affairs of the hospital. It was a simple division of authority—medical affairs handled by the physicians; management affairs handled by the administrators and trustees.

It was simple years ago, but is not so simple now. We have experienced such remarkable changes in medical science, medical practice and socioeconomics that we find the physician and the hospital with their functions so intermingled that their relationship is undergoing a needed thorough reexamination.

The growth of radiology, pathology and anesthesiology in hospitals and the unique financial relationships that have developed have tended to color the broader consideration of medical staff-hospital relations. Too often hospital-physician relations have meant hospital-radiologist or hospital-pathologist relations. Our opportunity and challenge is to go beyond this narrow approach and develop a sound partnership with our physicians and jointly work for expansion of our services to the public—most of which will be medical.

STRENGTHEN HOSPITAL ORGANIZATION

The task for hospitals is to strengthen hospital organization by providing more effective participation by physicians in hospital affairs without weakening or abandoning the normal trustee-administrator lines of hospital management. This means more responsibility and more authority for physicians, not only in the immediate care of patients where they already are the final authority, but in the other aspects of hospital operations.

It seems that some simple, yet effective, guideposts for improved action might well be established—or in some cases merely re-emphasized—which could serve to point the way toward the direction that hospital-physician relations must take in order best to withstand the strains and stresses that threaten the voluntary health system as we know it. I suggest the following guideposts:

1. All physicians must be recog-

nized as professional practitioners, and the same standards and procedures must be used in their appointment to the staff of hospitals. We should not perpetuate the idea that medical specialists, meaning by that radiologists, pathologists and anesthesiologists, are different.

2. The soundness of trustee authority over all matters must be recognized by physicians and trustees, but all medical matters should be delegated to the medical staff for elaboration of policies, procedures, review and self-government.

3. That the work may be done most effectively, hospitals should be departmentalized for medical matters and members of the medical staff assigned to departments according to their training and the nature of their medical practice. By and large, physicians should work in only one department.

4. Every medical department should have the best person from the staff as its head, with primary consideration being given to his abilities and his interest in professional administrative work in the department. The hospital organization should hold this person responsible for his staff and its work. Very possibly, this medical department head should have a longer term of office than has generally been the custom. Since election of a department head by members of the medical staff does not always result in the selection of the best professional administrator, hospital boards should sometimes appoint these medical department heads after thorough consultation with the medical staff and exercise of the best judgment that the appointment will be acceptable to the staff.

Physicians will resist this but it often is much better than open election. The selection can often be made with the use of a joint staff-trustee committee.

In larger hospitals, the department heads must be given assistance by the hospital in the form of office and secretarial help. If a large program in medical education and research is added to the department head's administrative duties, he usually must devote almost his entire time to the department's work and must be adequately compensated.

The primary element of resistance to the establishment of an effective department head system is the concern of other physicians about someone being in charge of them with authority over their practice of medicine. It will have to be made abundantly clear that the department head's authority is limited to the administration of the medical rules and regulations of the hospital as adopted by the medical staff itself.

5. The heads of departments, plus elected members from the medical staff as a whole, should constitute the basis membership of the executive committee of the medical staff or medical board. It is here in this executive committee or medical board that policies and procedures for the medical care of patients should be elaborated. Since this group's function is to set rules for physicians and their work in the hospital with all other groups, it is important that the hospital administrator be present and participate in deliberations. In my judgment, the chief nurse, the chief of radiology, pathology and other fully organized departments also should be on the board. The executive committee of the medical staff should receive regular reports and participate in discussions on the general operation, including financial operation, of the hospital because the hospital administration needs the help and understanding of the physicians the committee represents.

6. There should be regular methods established to review the quantity of hospital services utilized by staff members. There should be an audit of the amount of services used as well as a medical review of their caliber. Under a committee organization similar to that established to review the quality of medical work done by the staff, the department head should have this economic review as a major responsibility. In addition to department head responsibility and committee action, each individual physician should devote some attention to the problems of the economic and efficient uses of hospital services. Only by this mechanism can we answer effectively the question of overutilization of hospital care facilities.

7. In some areas, much of our trouble comes because of fear and apprehension that hospitals will extend the practice of employment of physicians, and that this, with time, could lead to a very undesirable domination of medical practice by corporations, especially where boards of directors or trustees are entirely nonmedical. To most hospital administrators, this seems like an unrealistic fear but, to some physicians, it is quite the reverse. In order to improve this situation, it is suggested that hospital staffs, boards of trustees and administrative officers consider agreements that physician employment by hospitals be made only after review of the plans to do so with a properly constituted group of the medical staff, such as the executive committee. This should give assurance that the hospital's plans were properly considered from a medical and professional point of view and provide the trustees and administrator with medical assistance in arriving at proper financial relationships between employed physicians and the hospital.

8. Physicians should participate with hospital administrators in presenting the story of medical practice in the hospital to the board of trustees. If the chairman or president of the medical staff meets with the board of trustees, the administrator can be furnished assistance in interpreting medical matters, and the staff can learn first hand of the trustees' problems.

PHYSICIANS AS BOARD MEMBERS

Whether physicians should be members of boards of trustees of hospitals has been discussed pro and con for many years. Those in opposition point out the conflict of interest involved. However, boards of trustees would profit by the participation of experienced physicians, where it is felt that conflict of interest would be a minor matter. This seems to work satisfactorily in many hospitals. If a physician is on the board, it would be important that he represent the hospital and the community as a whole and not be the representative of any specific group of hospital physicians and not necessarily

confine his participation to medical affairs.

9. The joint conference committee is an established device to bring medical and trustee thinking together. It should not be regarded as a substitute mechanism constituted to perform the functions or assume the responsibilities of either the board of trustees, the medical executive committee, or the administrator. It is more often a device created because the regular ways of administering a hospital's affairs do not always seem to work properly, and it is also a recognition of the unique position of the physician in the hospital organization. Used with caution and respect, the joint conference committee can be a useful communication channel between trustees, physicians and the administrator. Agenda items must be carefully scrutinized.

10. Hospital association and city and regional councils should consider the inclusion of staff physicians as part of the association and should establish special sectional activities for them. This would provide a mechanism for joint consideration of professional matters by the staffs of the region and stimulate the development of joint programs. This should not be considered a substitute for or a threat to the program developed by county, city and state medical societies, which have as major objectives the elevation of standards and quality of medical practice both in and out of hospitals. In addition to providing sectional programs for staff member representatives, hospital associations and councils should develop effective liaison relationships with the official medical societies and discuss in this setting problems of mutual concern.

11. Hospitals and physician specialists are going to have to develop satisfactory and fair arrangements for working with each other. The difficulties that have arisen in these areas have resulted from two basic factors: (1) These physicians have been treated differently from others associated with hospitals—in some respects, they feel they have been accorded only second-class citizenship. (2) Money has become a major source of contention—the finances of the physician and the hospital have become intertwined.

SPECIALISTS NEED RECOGNITION

The solutions are easy to enunciate but difficult to put into effect. These physicians should be accorded full professional recognition as members of hospital medical staffs, and there should be fairness on both sides in financial dealings. No one financial pattern is necessarily suitable for all communities. Each local situation may be solved to the satisfaction of the hospitals and the specialists involved.

In recent years, specialist societies have abrogated joint statements developed with the American Hospital Association and have been taking a unilateral position insisting on certain administrative patterns to apply in all situations. In view of this conflict, the AHA recently published its position as a guide to all hospitals. In essence, the AHA position is that the freedom of the hospital physician specialist to exercise his medical judgment and skill can be maintained under any of a variety of relationships which are agreeable to those concerned at the local level. It might be well to point out here that thousands of highly ethical physicians are providing high quality medical care under arrangements which call for widely varied methods of payment—including full-time salary. This is especially true in the stronger medical departments of our larger teaching hospitals and clinics.

To meet the growing demand for better and more comprehensive medical care, better organization will be required of physicians on hospital staffs in order to develop patterns for providing a wider range of services in outpatient clinics, rehabilitation units, nursing homes and related paramedical facilities. The whole concept of the regionalization of hospitals or of creating working affiliations between general hospitals and paramedical institutions can be established administratively with moderate ease, but it could founder and fail unless suitable, workable and agreeable professional arrangements can be made. The physicians will be apprehensive because of fears of domination and regimentation. They must be reassured that their professional independence will be maintained.

In turn, hospitals must be prepared to accept more physician direction and participation in the organization and development of the outpatient and emergency departments, for these are basically medical practice areas and will not reach effective development without the physician's enthusiastic help. Increasingly, physicians are organizing in groups with hospitals in order to provide the best and most efficient services to the public. Whenever this occurs or is suggested, there arise great cries of "domination", "regimentation", "third-party interference" and "corporate practice of medicine". Physicians and hospitals should be concerned about but not governed by these outcries.

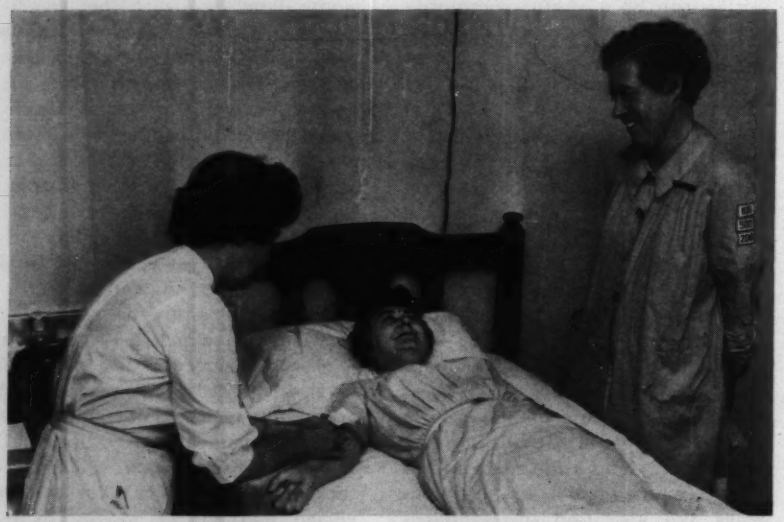
A UNIFYING RELATIONSHIP

The physician will have to be brought closer to the hospital in order that he may practice more intimately within the hospital environs. This is going to mean physicians' office buildings related to hospitals, increased use by physicians of hospital outpatient facilities, less duplication of services and expensive overhead in diagnostic facilities and many other efficiencies the American public wants of its health practitioners.

However, if physicians and hospitals are to work constructively together, neither is to dominate. There cannot be domination of physicians by hospital administrators. Neither can the physicians take over the hospitals, converting them into their own private workshops and ignoring the basic community-wide sponsorship and function of hospitals. The physician must know more about and take more of a share in the responsibility for the financial decisions of a hospital. If physicians and hospitals are to fulfill adequately their responsibilities in meeting national health needs in the years ahead, it will be essential that they work more closely together and come to a better understanding of each other's problems and attitudes. ■

Improving patient care through

by MRS. ELIZABETH WILKINSON



(TOP) Since its organization approximately five years ago, the committee for the improvement of medical patient care, one of several patient care improvement committees at the Grace-New Haven (Conn.) Community Hospital, has met once a month for lunch, followed by a one-hour business meeting, where problems are discussed and suggestions made for improvement. (BOTTOM) At the recommendation of the medical patient care improvement committee, routine laboratory work on all patients able to have this done is performed in the laboratory before the patient is taken to his room.

THE PHYSICIAN, the nurse, the administrator and all members of the team who provide care to patients in our hospitals today will not become effective until they learn to work harmoniously together as a team to achieve one common goal—optimum patient care.

Over the years, not only has medical and nursing care become more complex, but so have the many departments that make it a health team devoted to the care of the patient. There are medical meetings, nursing meetings, dietary meetings, laboratory meetings, as well as committees for this and committees for that. In the larger hospitals, however, communication between these groups has widened rather than run together.

On a state and national level, efforts have been made to coordinate the activities of the various health disciplines, but not enough has been done in our own community hospitals to develop a good line of communication between the various groups who are all trying to serve one master—the patient.

At Grace-New Haven Community Hospital, approximately five years ago, it was decided to adapt the concept of an improvement of patient care committee to a large university hospital. With the complexities of many services and both a university and general staff (often called private staff), we knew one committee would be too cumbersome. It was then decided to start with one area and, if the program was successful, extend it to other areas.

Patient care improvement committees, with the objectives of strengthening communications among staff members and encouraging discussion of problems, can be extremely useful in fulfilling the objectives of the hospital, the author states. She describes the operation of such committees at a large university hospital and some of the improvements—especially in maternal and newborn care techniques—brought about through recommendations of the committees.

Elizabeth Wilkinson is the associate director of nursing service, Memorial Unit, Grace-New Haven Community Hospital, New Haven, Conn.

STAFF SUPPORTED PROGRAM

From the start, we were fortunate in having the support of our director of nursing, who was a member of the state committee for the improvement of patient care, and the help of a private medical practitioner who was also a member of the state committee. Because of his interest and because we felt there were problems on the general medical service, we started

better communication

with a committee for the improvement of medical patient care. Since its organization, this committee has met continuously once a month. Its members include three private physicians, the resident house officer on the general medical service, the associate director of nursing, the medical nursing supervisor, head nurses from the general service medical divisions, the dietitians assigned to these divisions, the chief technician from laboratories and an assistant director of the hospital. Personnel from housekeeping, maintenance, transportation and other departments attend on a consultation or request basis. The group meets the first Monday of each month in a private dining room, with lunch provided by the hospital. The meeting is limited to one hour following lunch, and unfinished business is postponed to the next meeting because no one likes to leave his duties for more than an hour.

The secretary, who is the assistant director of the hospital, prepares an agenda before the meeting by asking the various members if they have problems they would like to present.

Following is a typical agenda:

1. Approval of minutes
2. Suggestion boxes
3. Laboratory specimens
4. Question of referral to committee of significant comment cards
5. Assignment of house physicians to patients
6. Special diets
7. Facilities for adequate care of critically ill or possibility of intensive care unit
8. Adequate secretarial help on one of the hospital floors.

SOME CHANGES MADE

Many problems have been discussed over the years in this committee, and at its suggestion, many changes have been made. In order to clarify the many phases of patient care covered, a few of these changes are listed:

1. Division secretary coverage increased to 16 hours per day, seven days a week.
2. Routine laboratory work performed in the laboratory prior to admission to the division on all patients able to have this done.
3. Intercommunications system extended to make it possible to talk from one nursing station to another medical division.
4. A revision of emergency equipment.
5. Routine afternoon nourishments discontinued, except for patients on forced fluids, because lunch and dinner were believed to be too close together.
6. More commodes were bought because physicians on the committee believed it is now good practice to get patients onto a commode sooner.
7. A routine time for weighing patients was set for 10 a.m. so that patients could sleep later, as physicians agreed this time was just as good as before breakfast.

These seven examples are only a few of the many things that have been accomplished and problems that have been discussed in the committee meetings.

ADVICE TAKEN SERIOUSLY

The original National Joint Commission for the Improvement of the Care of the Patient stated, "These joint groups at the national, state and hospital levels are designed to be advisory only." Our committee has found that although it is truly advisory in nature, its advice is taken quite seriously, and most of the suggestions are carried out. The minutes of each meeting are circulated to the director and his assistants, to the head of each department and to the chief of service. Not only are they circulated, but they are carefully read. Memos coming across the desks of department heads from staff members show that everyone in the medical center is really interested in just one thing—better patient care.

Frequently items discussed at the committee meetings come up again at head nursing meetings, and even before the hospital started its committee for the improvement of surgical patient care, there was great interest in developing such a committee.

The surgical committee is now more than two years old and meets once a month. Two surgeons from the attending staff, one urologist and one gynecologist, plus the surgical resident, make up the medical part of the group. The associate director, surgical supervisor and surgical head nurses make up the nursing group. The dietitians from the surgical divisions, a representative from laboratories and an assistant director from administration complete this committee.

One of the things this group has been successful in instituting is a satisfactory "prep team" for all surgical skin preparations. A male aide does all male skin "preps", and a carefully selected aide or licensed practical nurse does all female skin "preps". Both of these employees work from 3:30 p.m. to midnight. After they have prepared all patients scheduled for surgery the following day, they

help on an assigned surgical division.

Following discussions in the surgical group, a new form was developed for use in transporting patients to the radiology department. Formerly, the aides and orderlies who transported these patients came to the divisions with the patient's name on a scrap of paper. Now they have a printed form which gives the patient's full name and also tells the diagnostic test the patient is to undergo.

The committee also approved replacing the old-fashioned dressing carriage with dressing trays, accompanied by metal baskets with small bottles of solutions needed for dressings. These baskets and bottles can be autoclaved, as can the trays that are now used for dressings. No longer does one physician have to wait to do his dressings because someone is using the dressing carriage, and no longer do we "push" germs up and down the corridors on the wheels of the dressing carriage.

NEWEST AND OLDEST COMMITTEE

One of the newest and yet the oldest of these patient care committees is the committee for the improvement of maternal and newborn care. It is the newest because it has been organized under this title for less time than the medical and surgical committees; it is the oldest because it was the outgrowth of two committees of long standing that were concerned with the care of the mother and child. One group had worked on a manual for newborn care, and the other group were physicians and head nurses who had started, on their own, a discussion group at lunch twice a month.

At Grace-New Haven Community Hospital, the university obstetric and pediatric services work closely with the private or general service obstetricians and pediatricians. This group is composed of four chiefs of service, representatives from both the obstetric and pediatric house staff, head nurses, nursing supervisors from both the obstetric and pediatric departments, the associate director of nursing and the director of nursing, an assistant director of the hospital, who serves as the administrative person for this group. Because there are many social service problems in this area, the director of social service also attends the meetings.

Since this was a larger group, and some of its members were not familiar with the philosophy and objectives of committees for the improvement of patient care, the following was developed at the first meeting:

Purposes of the Committee for the Improvement of Maternal and Newborn Care

I. Philosophy

To promote optimum care for all mothers and newborns admitted to the Grace-New Haven Community Hospital.

II. Objectives

1. To provide, through frequent meetings, an opportunity for good communication among those concerned with the care of mothers and newborns.

2. To evaluate, coordinate and simplify existing regulations, routines and standards, and to formulate and recommend new ones.

3. To ascertain patients' reactions to their hospitalization and follow-up.

4. To encourage effective teaching of obstetrics and newborn care to physicians, nurses and students of medicine and nursing.

5. To evaluate proposed research projects, to approve projects and authorize their prosecution and to review periodically the operation of current projects.

Because of many and varied requests for permission to do research on the obstetrical service, it was believed that the last was a necessary part of this committee's objectives.

The committee for the improvement of maternal and newborn care has discussed many things that affect the care of both mothers and newborns. They have:

1. Reviewed and revised policies concerning the appropriate dress for all staff going to and from the delivery suite.

2. Developed a more satisfactory system for the notification of pediatricians on the birth of the newborn.

3. Standardized university and general service nursing standing orders so that all nurseries now have the same orders.

4. Changed the lighting and color of nurseries for better detection of jaundice.

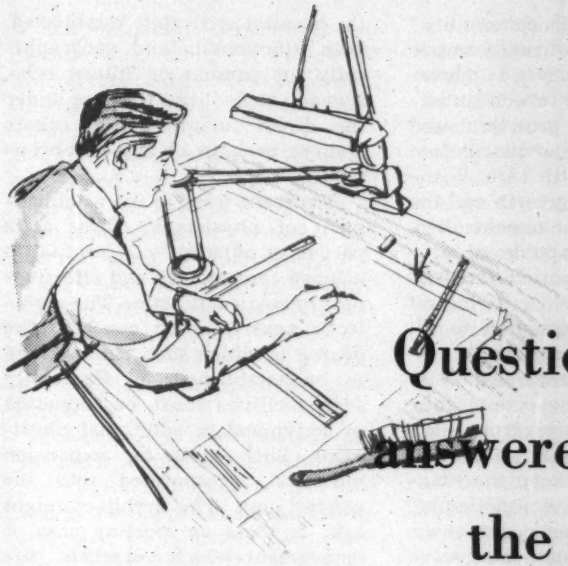
This committee has frequently discussed the many research projects being done on the obstetrical service. Because of the many different procedures and policies on obstetrics and in the nurseries, many of these have been discussed and clarified. Although it fundamentally serves the same purpose as the medical and surgical committees for the improvement of patient care, this committee differs in meeting the needs of those involved in its actions.

COMMITTEES MEET NEEDS

Each patient care improvement committee should be set up to meet the needs of the hospital of which it is a part. Perhaps in a smaller hospital one committee for the improvement of patient care is sufficient; perhaps in some hospitals committees should be combined to work together. Some may need to meet once a month; others every two weeks. Only by exploring individual needs can each hospital have success.

Not only do these committees discuss and solve problems, but more important, they develop mutual understanding. Nurses, for example, have more understanding of the physicians' problems just as they have more understanding of nursing problems. To the head nurses, the laboratories are no longer just angry voices at the end of a telephone, but they are people who are just as anxious to see that patients get the best possible care. Nurses know, too, that dietitians have problems and that nurses are not alone in their desire for good patient care. The director of the hospital, the heads of departments and chiefs of service who read the minutes of these meetings are kept aware of the many small problems that complicate patient care. Communications successfully reach all who are interested.

In today's complex hospital, no one group can give total care. Only a team working harmoniously together can achieve the goal of optimum patient care. ■



HOSPITAL PLANNING:

Questions to be answered before the architect puts pencil to paper

by ROGER MELLEM

The importance of accurately programing or preplanning hospital construction will never suffer from overemphasis, the author states. He recommends objectivity in examining both existing and proposed health facilities rather than confining planning to the narrowness of one project, which can be potentially detrimental to any or all such facilities. Questions regarding specific features of individual projects are set forth and discussed.

IN the case of either new hospital construction or expansion of an existing hospital, before the architect puts pencil to paper he will determine first: Does the community have a master program that coordinates the health care activities and facilities within the area? Then, as a second question, he will ask: Does the program show an inventory of services and of existing beds for various types of care, and does it show how they are distributed?

The answers to the two foregoing questions, plus the answers to many others, form the foundation for the functional program of a construction project. As it is developed, the functional program effectively aids in establishing the new organizational structure as the basis for the hospital's operational policies.

Architecture is the esthetic enclosure of space designed primarily for a specific function. An architect is a person skilled in the art and science of designing the enclosure. He must have a clear and concise statement of the needs that are to be satisfied by the structure he creates. This is especially true for the complex structure called a hospital.

The statement of needs to be met and services to be provided constitutes the functional program. Writing a functional program should always precede the writing of an architectural program.

When the architect has an accurate statement of the functional program, he can begin on the architectural program, establishing a clear statement of the design problem he is to solve. He should not be expected to make assumptions. The more he has to make, the greater the chances of his misinterpreting the problem and ending with an undesirable solution. Although the architect can't be expected to decide on the services to be provided, he can assist in reaching decisions on these matters.

Formulation of the architectural program expedites the design phase, because the architectural program establishes early agreement on numerous features of the project and eliminates possible future misunderstandings.

Since the turn of the century, medical science has been gaining momentum. With every advance in medicine, the physician and his patient have become more and more dependent on medical facilities provided by the community and centralized in one place, the focal point of life-giving and life-saving activities, the hospital.

MORE THAN A BUILDING

This hospital is more than buildings housing equipment. It is an aggregation of functioning professional people who care for the sick and injured; educate physicians, nurses and other personnel; administer to public health in the prevention of disease and the promotion of health; and foster research. Unless their abilities are of high quality and their services are utilized to the utmost, any increase in facilities may give the community a false sense of security in its program for adequate medical

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This article is adapted from a presentation by the author at the 1960 New England Hospital Assembly, Boston, as one of four panelists discussing "The importance of a functional approach to hospital design for modernization and new construction".

care in the hospital.

An appraisal of the conditions by a qualified hospital consultant could save the hospital and the community from making serious mistakes. The consultant will understand the dynamics of community involvement, which is basic to sound planning and to successful fund raising. Both of these are vital to any project.

Some may think that demographic data and highway distances are sufficient evidence to justify the establishment of new hospital facilities. Of equal, if not more, importance are the answers to these questions: Are all the present facilities, including personnel, being utilized as effectively as possible? Will the professional care in all facilities be of high quality? Are the existing facilities generally accepted by both patients and physicians, or would new or additional facilities substantially increase hospital usage? Is the community willing and able to finance additional facilities and services?

DUPLICATION: THE UNPARDONABLE SIN

Duplication of expensive services is unpardonable if it results in uneconomical utilization of the services. For example, in one community, space and equipment for open heart surgery have been duplicated. Justification for the duplication is lacking for two reasons: there aren't enough patients who need this type of service and qualified staff members are not available. Another example exists in a community of 40,000 people in a southern state, cobalt radiation units have been installed in three hospitals; one could serve the community adequately.

The hospital's governing body, then, should take the lead in the proper anticipation of services necessary to fulfill the community's needs, and the important first step is the establishment of a master program for the hospital as it relates to the over-all master plan of the community. There are actually two parts of a master program, the written and the delineated, and since the delineated part seems to be referred to oftenest, we speak of the whole as the master plan. Thus, the architect's next question is: Has the hospital taken this first step so essential to the successful growth of a community?

Many of us are not really aware of the importance of a master building plan which reflects anticipated community growth based upon the trends in the distribution of medical and health care. Without it, a hospital's growth can too easily develop into an uncontrolled, geometric Topsy capable of providing only unorganized facilities for patient care. With it, logical priorities can be assigned to all elements of the program.

The architect's next question is: Has the hospital's governing body set up a regulatory group—the governing body itself or a committee from it—to keep the long-range plan alive and functioning, to keep it from being put away, allowing good, fundamental work to atrophy?

FLEXIBILITY STRESSED

Several hospital organizations, recognizing the importance both of conception of the master plan and the control of it, now retain architects on an annual basis so that the plan may be modified as new trends and data become available. We speak of flexibility as an important part of successful contemporary architecture, but we should remember that in hospital design the foundation for this success is set down on a master plan that in itself shows the elements of flexibility.

If a master plan does exist, the architect might ask these questions regarding elements it should contain: Does it accurately indicate subsoil factors; storm and sanitary sewers; water, gas and electricity lines; steam lines and tunnels? All of these figure importantly in the location of future buildings. Have all the latest revisions to the zoning ordinances and building codes been studied so that such regulations as setbacks and ground area coverages are familiar items and are adequately accounted for on the master plan?

Does this master plan recognize the increasing importance of facilities for long-term care for which the hospital is responsible both to itself and the community? Does it provide for these long-term facilities the necessary land area and proper juxtaposition to other buildings? Or, in place of this, has the hospital accurately established, both functionally and geographically, its present or future relationship to facilities that are under the direct jurisdiction of others and are, perhaps, on adjacent property?

A current trend is the establishment of physicians' offices as a part of or adjacent to a hospital to achieve convenience and effectiveness in medical practice. The architect's next question concerns the degree to which such facilities are to be established, as frequently such facilities must be increased to accommodate additional physicians. Such ideas for expansion must be incorporated into the master plan. The architect might ask: Is there an existing area or department which currently suffers uneconomical use and which could be converted into physicians' offices, which are a desirable asset?

In connection with provisions for physicians' offices, the architect should ask this question: Are the community needs for outpatient facilities being properly anticipated? Too often hospitals have omitted this function in their original planning. With rare luck, some hospitals have added them later without their becoming makeshift arrangements quite unsatisfactory in handling the heavy load forced upon them. Consequently, in the design of new buildings, allowance should be made for the addition of this important function.

Regarding the outpatient department, these questions need answers: What is the total population that could be expected to use it? How many physicians are estimated to be needed on the outpatient staff, and how many will be working in the department at one time? What is the estimate of how many patients can be seen per day in an examination room, and how many rooms will be needed? Will the arrangement and construction of the rooms give the necessary privacy, considering that the patients represent various economic classes and have a variety of illnesses? Will there be any space for specialized treatment or examination? Should the department be designed on a double corridor plan? Keeping in mind how the corridors will be utilized, how wide should they be?

The outpatient department can become quite complex, but one of the secrets of its success is keeping the patient from realizing how complex it is.

Other questions are: Can the outpatient department be allocated space on the ground floor, with its own separate outside entrance and without steps to be climbed? Will it be readily accessible to the main administrative area, especially the medical record room? Will the entrance be as isolated as possible from the area occupied by inpatients?

For economy, the outpatient department should take advantage of the hospital's adjunct services used also by the inpatient service. However, site peculiarities may cause the architect to ask the next question: Does the value of time and economy justify provision of duplicate adjunct services?

Convenient access without complicated and undue traffic should take outpatients through part of the hospital to the pharmacy, laboratory, radiology, physical therapy and rehabilitation areas. It should be determined whether the rehabilitation areas, which include the occupational therapy area, will be available to staff after hours. This may be an important public relations item in regard to enticement of qualified personnel.

PSYCHIATRIC FACILITIES PROVIDED

The architect's next question might be: Has consideration been given to outpatient care for the psychiatric patient? The program for treatment of the psychiatric patient within the community gains momentum daily, and the hospital should be prepared to fulfill this need when necessary. If psychiatric inpatient facilities do not exist in adequate proportion near by, they should be considered for inclusion in the construction program. Of course, it should first be determined whether a professional staff of high quality is available.

If this type of facility is to be included, the next question should be: Have professional organizations of psychiatrists who have developed important information on design been consulted in order that hospital psychiatric work can be done more effectively? Part of the information they may give may be a little startling but, upon close examination, the planners will see that it is based on good logic, fortified by years of experience. Architectural design should be highly influenced by their concepts, for it will be found that good design can be highly influential in the treatment of patients.

University architectural departments have new ideas to offer, and recently these departments have generated a great deal of interest in hospital design. More will follow. Therefore, the architect and his hospital client should ask themselves: Have we been willing to watch and learn from them?

The architectural departments of Harvard, Massachusetts Institute of Technology and Yale have considered the concept of progressive patient care important enough to assign to their advanced architectural classes the design of a new progressive patient care hospital as one major design problem each year. Other schools have also given this type of problem.

The next question obviously is: Is this the concept to follow in our construction program, and, if it is, shall it be followed completely? It may be done only to a certain degree, perhaps by the general care facilities being modified to include an intensive care section. Those responsible for such decisions should ask themselves if they believe the value of new concepts has been proved satisfactorily so that major changes can be undertaken. Whatever is done, as much flexibility as possible should be a major characteristic of the work.

MODERNIZATION QUESTIONS

From the many noteworthy guides in the *Manual on Hospital Planning Procedures*, published by the American Hospital Association, the following two paragraphs contain a number of important questions regarding modernizing and expanding a hospital:

> "Where should a program of modernization and expansion start? A list of known needs and desires will give a good start, but they also lead to many difficult questions. Is the old hospital worth modernizing, especially if the grounds are so crowded that expansion is difficult now and will be well nigh impossible in the future? Would it be better to abandon the old plant and build a new hospital farther out of town where enough land is available for auto parking and for future expansion? If it seems better to stay in town and modernize, how large an investment can be justified for the old building and how much for new additions? Can the cost of modernization be justified either by anticipated savings in operating costs or by an improvement in the quality of service? How can a building program be carried on without interrupting vital hospital services? How can needed funds be raised when there is so little popular appeal to fixing up an old building? How can adjustment be made between variations in operating methods dictated by an old and a new building? How can the true residual value of the old building be estimated so that the cost of improving it can be fairly appraised? How can the old building be made attractive enough to avoid accusations of alleged discrimination when staff assignments are made to the new or old building? And lastly but eternally, how can the expanded areas, which usually total less than the combined departmental requests, be allocated equitably among the departments? This is the most difficult planning question of all.
>
> "These are not hypothetical questions but real ones which arise on practically every modernization and expansion project. There is no stock set of answers to them . . . Undoubtedly some modifications in approach will be required in reaching a satisfactory solution."

The availability of qualified personnel is an important factor and is sometimes overlooked. It affects the scope and size of any project. If availability and desired scope are compatible, the architect can then ask the question: Has careful consideration been given to the percentage of staff who will live on the premises and the percentage who will live elsewhere?

The trend is for the staff to live away from the hospital, and this requires much larger accommodations for changing and storing

clothing. Several hospitals are experiencing serious growing pains in this respect. This is another prime concern in the master plan, whether space is to be allocated to living quarters, either at the present time or in the future.

The addition of new services might be considered, and the next question could be: What are the advantages of locating the county health officer and the visiting nurse association at the hospital?

Another question might be: Is there an advantage in providing facilities for programs in health education at the hospital? Just one of several might be a program in the control and treatment of tuberculosis.

This leads to another question: Has the need for a tuberculosis unit within the hospital been investigated? Differences of opinion exist in various parts of the country on this question. In areas of high prevalence, it is thought that the care of tuberculosis patients should take place in separate hospitals rather than in tuberculosis units of general hospitals and that new construction of this type should be located in areas that permit easy conversion to other use. However, in areas of lower incidence, units for this type of care are being encouraged for the general hospital.

HOW LARGE A NURSING UNIT?

Several questions need answers regarding the size of nursing units. How are the beds to be distributed according to services? What will be the bed capacity of each nursing unit? Have the units heretofore been too small for efficient utilization?

How many single versus double rooms will there be? A group of physicians in a city in New York made some interesting comments regarding the advantages of private accommodations. Among them were these few: less chance of cross-infection; no roommate incompatibility or friction arising from the other patient's inconsiderate visitors; no chance that a patient will witness depressing scenes, such as the death of a roommate; no objectionable noises or odors in the room. Also, in communicable disease cases, the private room with its own toilet and lavatory is an ideal isolation unit. Frequently, the physician gets a more detailed, reliable history from a patient because of the privacy, and he can perform a better physical examination without embarrassing the patient.

Of course, the advantages of the double room are important: lower cost to the patient, companionship (if the patients are compatible) and the comfort in knowing that a companion can summon aid if the other person gets into difficulty. Also, one must consider the levels of service to be provided and include not only single or double rooms but units of four or six beds as well.

EMERGENCY FACILITIES

The architect ought to ask some questions about the emergency department, a department that plays an important role in the hospital's public relations, not only in the local community but in the state or even the country, because an emergency can happen at any time, in any place. To one who suffers and survives an emergency, the entire experience remains as an indelible imprint, and if the emergency department of a hospital is ill equipped in material and qualified staff, good public relations on behalf of itself and other hospitals may suffer.

An obvious first question is: Approximately what is the anticipated daily number of emergency patients? This question is difficult to answer. For example, an eastern university is situated in a lovely, usually quiet city in a usually quiet part of its state. When a new hospital was built at the university for use of the whole community, the size of its emergency department was based on past experience.

Apparently, peaceful attitudes changed unexplainably, and a great strain was placed on the emergency department. Anticipation of community change is almost an art; it can be kept from being a too difficult one if persistent attention is given the master program for the community.

Another type of emergency is the hospital's own and its most dreadful one—fire. Currently the National Fire Protection Association is revising its section for hospitals in the Building Exits Code, and all planners should be alert to its publication and take heed to its suggestions.

HILL-BURTON LESSONS LEARNED

Another question is this: What lessons can we learn from the Hill-Burton program? The remarkable staff of the U.S. Public Health Service that designed the model elements for the program has made an analysis of 138 hospitals built under the program. This should be examined by planners for the benefits it contains. In addition, the Hill-Burton program director in each state has a wealth of experience to draw upon.

The Duke Endowment has conducted a survey of Hill-Burton hospitals in North Carolina and South Carolina, and the results of this study are worthy of careful study.

In developing its long-range planning, has the hospital studied the need in the community for an isotope laboratory? The use of radioisotopes is widening into larger circles of possible uses, diagnostically and therapeutically.

The question of whether to provide for a cardiopulmonary laboratory needs answering. Is there an existing facility in the community capable of handling the demand? These are not commonplace items found in every hospital, but this fact does not exclude them from consideration.

THE HOSPITAL AND CIVIL DEFENSE

In the nuclear age, a highly important question is: What is the hospital's role in the community civil defense program? If, among other things, soil conditions permit, what part of the hospital should be built underground for survival purposes? Should it be constructed to withstand great shock from relatively close blasts? Or should it be constructed to provide fallout protection? Besides space for human shelter for prolonged periods, should operating rooms, central supply and diagnostic services be included?

Usually one of the last considerations is site development. This is not right. Granted, it is probably more important for most patients to see their physicians than it is for them to look at the landscape.

(Continued on page 125)

CREATING AN OFFICE FOR THE ORGANIZED MEDICAL STAFF

(LEFT) At Peninsula Hospital, Burlingame, Calif., the medical staff secretary must be familiar with medical terminology, as she is often required to take down the proceedings of staff committee and section meetings. (RIGHT) One of the responsibilities of the secretary is to collect and post notices on the medical staff bulletin board. Bulletins announce meetings and keep physicians informed of other activities.

by RICHARD W. BLAISDELL

In recognition of the volume of clerical work connected with an active medical staff organization, one hospital has created the position of medical staff secretary and has provided an office for this work, the author reports. He discusses the advantages of this arrangement, noting that individual medical staff members have strong identification with their own office, and in addition have the advantage of a private facility for interviews, disciplining and confidential exchange.

IN MANY medium-sized general hospitals, the clerical and administrative functions pertaining directly to and arising from the organized medical staff take place either in the administrative offices, or in the medical record office. In some cases, the responsibility for these functional duties is shared by the two areas.

As the direct result of the analysis conducted and recommendations made by the Hospital Counseling Program of the American Hospital Association in late 1959 to the Peninsula Hospital, Burlingame, Calif., the administrator and medical staff studied the possibility of completely separating the secretarial functions of the medical staff from the existing administrative arrangement. The following conclusions were reached:

1. Regardless of the degree of mutual respect that may exist between the medical staff and the hospital organization, the fact that physicians must depend directly on "administration" for the conduct of their internal affairs is a psychological hazard with greater dimen-

Richard W. Blaisdell is the administrator of the Peninsula Hospital, Burlingame, Calif.

PROVIDING a separate office and secretary to handle the necessary clerical work of the medical staff has been the solution at the Peninsula Hospital, Burlingame, Calif., for lightening the work load of other secretaries and improving hospital-physician relations.

(LEFT) One of the qualifications of the staff secretary is to be able to work under pressure and to pay close attention to numerous details for short periods of time. (RIGHT) The secretary uses duplicating machines in preparing bulletins and reports for distribution to the staff.

sions than is frequently recognized. To offset the vague feelings of unwanted dependency and to establish the appearance of "separation" from administrative control, artificial behavioral patterns are resorted to by certain physicians.

2. If sound procedural patterns are to be established for all phases of the medical staff organizational work (notices, agendas, minutes, correspondence and scheduling and coordinating times and places of meetings), it is necessary to recognize the volume of the work load and then to provide adequate staffing to handle this work load.

3. The drain of effort imposed on the staff of either the administrative department or the medical record department, or both, by a large, active medical staff seriously hampers the employees of these departments in concentrating on their primary tasks.

4. The establishment of a separate office for the medical staff, complete with a paid secretary, can overcome the specific disadvantages cited and can achieve many benefits.

When the new position of medical staff secretary was created at the hospital, the following job summary and qualifications were decided upon:

The medical staff secretary is required to perform general clerical work, and she needs to know medical terminology. She takes dictation in shorthand of medical reports, letters and minutes of medical staff committee and section meetings. She transcribes recorded and direct dictation using a typewriter, prepares periodic reports on various hospital activities for the medical staff, maintains a current calendar of all staff meetings, prepares agendas (notifying members in advance), maintains a file on all

members of the medical staff, writes routine correspondence on her own initiative and performs related clerical duties.

The secretary must be able to fill the following performance requirements:

Responsibility: Accurate transcription of dictated material and records and orderly condition of files; liaison between committees and sections of medical staff.

Physical demands: Sits at desk most of working day. Finger dexterity and eye-hand coordination is important in taking dictation and typing. The secretary will be required to walk short distances, and she will stoop and bend when using the files.

Special demands: Courtesy and cooperation in dealing with staff members. She may be required to work rapidly for short periods under conditions of frequent interruption. She will be required to pay attention to numerous details for short periods of time. She must be able to use initiative and judgment in answering correspondence. She will work independently, performing a variety of standardized clerical tasks.

Personal qualifications for the job include:

Education: High or commercial school graduation with courses in medical terminology, stenography and typing, English and some mathematics. Two years of college are preferable, including a course in medical secretarial work.

PREVIOUS EXPERIENCE

Training and experience: Experience as a secretary or stenographer in a hospital or related health agency is required, and some editorial training or experience is desirable.

Job knowledge: Must be familiar with a system of shorthand, be able to type a minimum of 45 words a minute and make simple arithmetic calculations. Familiarity with medical terminology, rules of grammar, spelling, punctuation and hospital routine is essential.

The secretary works in a clean, well lighted, heated and ventilated office.

Job relationships include the following:

Source of workers: Secretaries, stenographers and typists.

Promotion from: Secretary; stenographer.

Promotion to: No formal line of promotion. May be promoted to administrative secretary.

Supervised by: Chief of staff and administrator jointly.

Works closely with: Chiefs of services, chairmen of staff committees.

WHAT WAS ACHIEVED?

The following gains from transfer of function to separate office and a medical staff secretary have been achieved at Peninsula Hospital:

- Issuance of meeting calls by using the bulletin boards, postcard notices, agendas, etc.
- Taking minutes of a majority of committee meetings* and transcribing, recording and publishing them.
- Taking attendance at committee and regular staff meetings.
- Taking care of the medical staff bulletin by collecting, correlating, publishing notices, calendar of events, meetings, etc.
- Planning programing and scheduling by arranging programs, seminars, etc.
- Providing a point of contact for staff applicants, hospital departments, outside agencies, coordinating intercommittee work.
- Channeling organizational flow of comments, complaints, or contacts within or out of staff organization.
- Handling all correspondence and official secretarial duties for the staff, its officers and committees.
- Collecting and disbursing staff dues.

In addition to the strong identification of the individual members

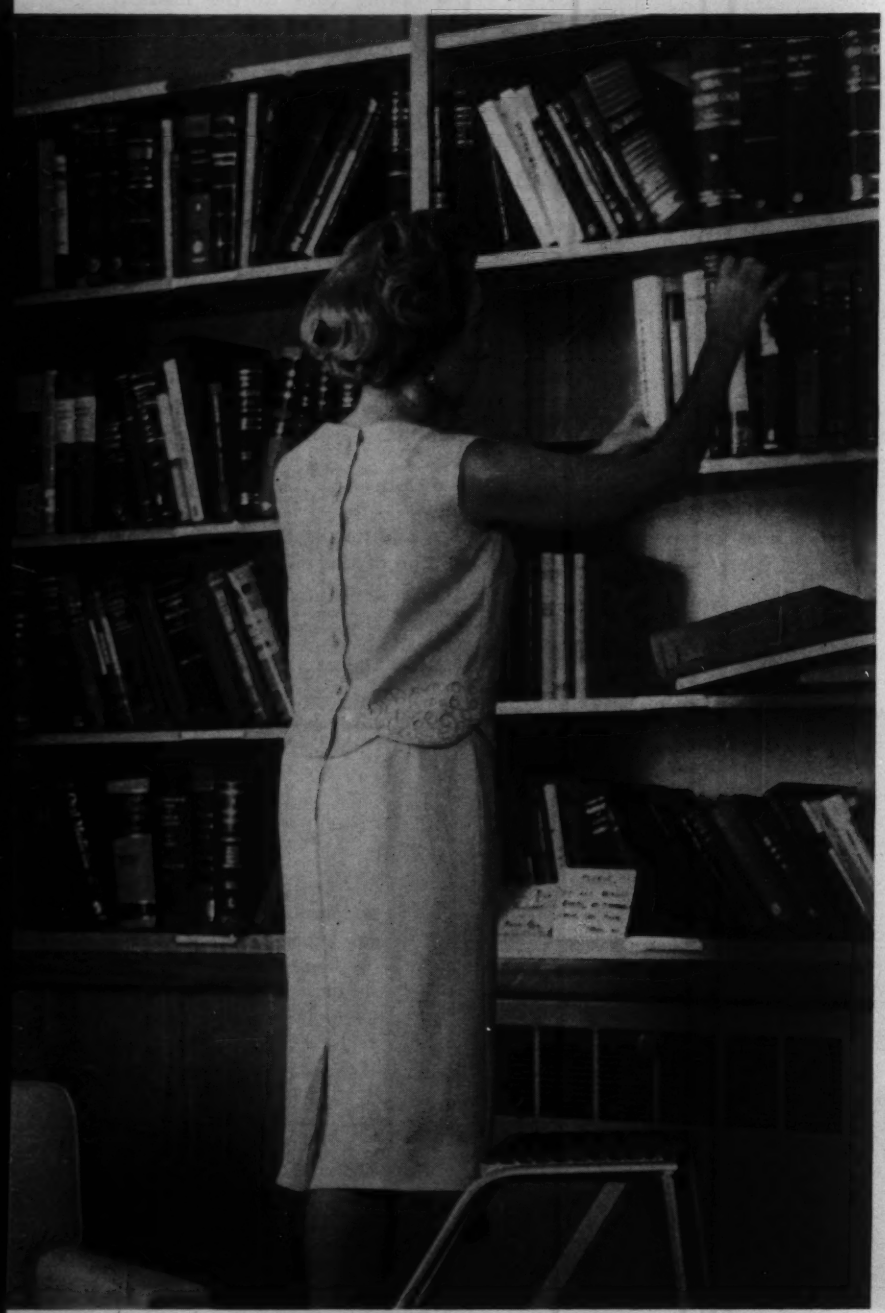
*Sensitive committee functions such as credentials, tissue, etc., are not normally included in the meetings which the lay secretary attends.

KEEPING track of the medical staff is another task the secretary performs. Here she lights signals, indicating physicians presently in the hospital.

of the medical staff with "their own" office, the privacy for interviews, disciplining, confidential exchange, etc., afforded by this separate facility, which is free from the influence of any other hospital activity, is most important.

Our experience has indicated that the stature of administrative personnel and department heads has increased in dealing with the medical staff when the staff is served by a separate secretary and office. The word "ex-officio" begins to take on significance when the holder of that title is not "carrying water on both shoulders", or taking minutes while attending staff committee meetings, or dealing with officers and chairman of the staff.

In the smaller hospitals, the separate medical staff secretary and office could be logically combined with the tumor board and registry department, or some other similar staff-oriented function.



GENERAL knowledge of medical publications is helpful when the secretary is called upon to collect reference material from the medical library.

STAFF MEMBERS COMMENT

Following are some typical comments which were made concerning the separate facilities for the medical staff by several hospital staff members including, the chiefs of the surgical and internal medicine sections, chairman of the infection control committee, chairman of the general practice section and the assistant administrator:

"A separate office for the secretary of the medical staff greatly enhances the work of all the committees of the staff."

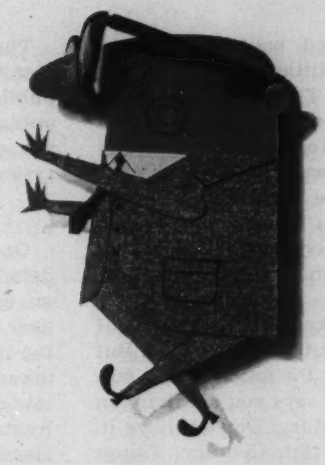
"I believe that a separate office for the secretary of the professional staff is a good idea because of the increased activity going on in that office."

"A separate office for the secretary of the professional staff is very desirable in order to save confusion in passing information between committees. I often find another committee member in the office while I am there. A separate office is more comfortable and convenient."

"Many of the matters discussed, considered rather confidential and often involving personalities of the medical staff itself, have the benefit of a confidential atmosphere of a separate office."

"I feel that by establishment of a separate office for the secretary of the professional staff, the image of administrative control and dictation is greatly reduced. The medical staff look upon this person as their immediate employee and would, therefore, not feel that the administration of the hospital is attempting to dictate and control their thoughts and actions."

"Separation of hospital administrative functions and medical staff functions by the establishment of a medical staff office and secretary has enhanced the relationship between the administrator and the medical staff." ■



HOW TO BE AN UNSUCCESSFUL EXECUTIVE

by HENRY A. DAVIDSON, M.D.

Being an executive is a difficult job, the author admits, because the responsibilities are back breaking and the ulcer rate high. Unfortunately, the secret to executive success is not known, the author notes, but the principles of failure are easily outlined. He presents these principles in 10 easy-to-follow steps and discusses several of them in detail.

THE SECRET of success I cannot give you. If I knew it, I'd keep it a secret. Instead, I shall give you the secret of failure, spelling it out step by step.

Lesson 1. Try to please everybody. The executive housekeeper argues that cleaning up the wards is a housekeeping operation, not a nursing function. She is very convincing; so you say, "Yes, you're right." In comes the director of nurses. Getting your private ear, she makes a splendid case for all aspects of ward housekeeping being *nursing* functions. So you say: "Yes; you're right." That way, you have pleased everybody.

Lesson 2. You can win affection and assistance by parading your physical disabilities. Take antacids after every burp. Swallow tranquilizers while in the office. Take long periods of sick leave. Complain of fatigue. Let the rumor start that you are falling apart. Everyone loves an invalid.

Lesson 3. Adopt a "devil-may-care" attitude about your clothes. After all, you're the boss, and who would criticize you? Preserve the soup stains on your necktie. Keep your fingernails in mourning. If you're late for the office, shave after luncheon. What's the difference if you have a stubble on your face all morning? And the woman executive has a perfect right to look like an unmade bed.

Lesson 4. Refuse personal interviews with department heads on the grounds that all your wishes are printed in the procedural manual. If you're asked an interpretation of a rule or a memorandum, retort: "What's the matter? Can't you read English?" In this way, you can never be blamed if your staff makes a mistake. People just read the memorandum wrong. That way your office won't be cluttered up by subordinates.

Lesson 5. Be the casual type. Don't let your board think that the organization is your whole life. Show the members that you have other interests. Play it cool.

Lesson 6. Just to show how reasonable you are, explain everything.

Lesson 7. Don't stick *your* neck out if the subordinate or department head makes a mistake. Why should you take *his* rap? In fact, you can boost yourself by his errors—repudiate his activities and show everybody that the mistake was none of your doing.

Lesson 8. Don't decide anything yourself. Instead of making a decision, refer it to a committee of department heads. Make them bring in a unified report. If they can't agree, knock their heads together until they do. Then follow through on their joint recommendation. If it doesn't work out, you can always blame them.

Lesson 9. Be openly modest. Don't let people ever say you're ar-

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This article is adapted from a presentation given at the New Jersey Association of Convalescent Homes and Homes for the Aged, April 19, 1961.

rogant. Instead, belittle your own views and abilities.

Lesson 10. Throw the union organizer out of your office. If he says "Good Morning", don't answer him. An answer would mean that you recognize him, and you don't ever want to do that. Of course, other executives may find that a responsible union leader makes for stability; he screens out trivial grievances. And others say that if you can't lick them, join them. But don't. Throw the union leader out. The calendar says you are living in the 20th Century. Don't believe it. Live in the 19th Century. Things were cheaper then.

Here, then, are 10 ways to be a failure. Let me discuss some of them a bit less sketchily.

Lesson 7 refers to deserting the subordinate who has "goofed". Actually, I'm sure you know that it may be necessary for the executive to support bad staff decisions that are made in good faith. The subordinate has to feel that his chief will back him up if he uses his own judgment. If you openly repudiate him, he is going to hesitate to make decisions. The executive who does not support an erring department head has discovered a way of being right all the time. He can endorse what is right and repudiate what does not work out well, but he buys his 100 per cent rectitude at too high a price. He forfeits the loyalty of his subordinates, gets a reputation for cowardice and selfishness and eventually breeds a corps of incompetent, indecisive and disinterested subordinates.

Most people are friendly, and the executive's chief concern is in getting along with other human beings. Some executives are naturally folksy; some assume the trait because they think it makes them popular. In pursuit of folksiness, an executive may dress like a country squire, smoke a pipe, greet visitors with elaborate casualness and encourage use of first names. He fears that he may be considered a snob or a stuffed shirt. Or he may drive an old car and send his children to public schools even when the public schools are not good. Whom is he fooling? If his salary is 10 times that of a clerk, the clerk is not going to confuse the executive with another humble worker.

The folksy approach impairs dignity, seems like a fraud on the public and corrodes the executive's authority. A strong executive does not operate his office on the "buddy system".

DETAIL WORK, PAPER WORK

One problem of the executive is detail work. Tradition has it that an executive is too big to sweat over details. But let me say this: if the executive has never been able to receive, understand and manipulate details, he will be manipulated by them or by those who do understand them. Without a secretary to pick his way through the files, an executive may be lost. Such an executive is heading for trouble. It is not good to be that dependent on anyone. He should watch out for the staff assistant who is eager to relieve him of details, because "the boss is too important for such trifles". Before long everything will be a detail.

There must be no scorn of paper work. In the modern world, power is made of paper. The law is written on paper, and so are regulations, procedures, newspaper releases and scores of other instrumentalities of authority. While the executive need not be enslaved by chains made of red tape, he must, in the last analysis, know enough about the paper work to be able to control it.

One serious problem of executive control is the fact that no one really loves the boss, and, being human, most bosses want to be liked. Some contend that it is possible to be firm with a subordinate and at the same time retain his affection. Although this is the case in healthy parent-child relationships, it is a mistake to think of organizational relationships as analogous. Here and there, there will be an occasional employer-employee relationship that mimics the family pattern. By and large, however, it is not like that at all. There is no way in which an administrator can take an action that will deprive an employee of a promotion, of a holiday, or of a pay raise without at the same time making the employee dislike the executive. Sooner or later every administrator has to face the fact that he is going to make decisions that some of his subordinates will not like. When he finally comes to accept with good humor the fact that some of his employees will dislike him, and when he can overcome his anxiety at this, he has matured into a real executive.

In today's world, youth is clamoring for recognition. Older persons in control of organizations emphasize experience in sheer self-defense. The young person has vigor and more modern training, and he is a more appealing figure. To protect themselves, therefore, the seniors say, "Well, you can't beat experience." Now, it is true that to some extent experience is irreplaceable and that many things can be learned by experience that can never be taught in formal training. However, experience by itself is insufficient. Sometimes it means no more than the privilege of repeating the same mistake. Unless an organization is actually going bankrupt, it is always possible for the executive to say: "Well, we are getting along all right doing it this way, so why should we change?"

HOW TO SOFTEN AUTHORITY

The administrator must be authoritative. To those concerned with the dignity of man, strong authority may suggest discipline, tyranny and officiousness; yet without authority administration is nothing. Ultimately the administrator's will is going to be imposed on the subordinate. This is a naked way of putting it, and it may be more acceptable to say that the administrator *teaches* or that he *furnishes leadership*, or that he gives *suggestions*, or that he *supervises*. But these are euphemisms. When the chips are down, administration must be fortified by authority.

Authority includes the right to impose sanctions or otherwise enforce compliance. Authority becomes acceptable to men and women of principle only because they voluntarily assume their subordinate roles and because with the executive they share a common goal. The entire authority structure, then, should be a freely assumed and highly motivated partnership toward a goal that all desire. A successful administrator shapes his authority so that it is

softened by these two concepts: the common goal and the partnership.

The main difference between a job and a career is a sense of self-respect and pride in the work. Thus, the employee must be convinced that his work is important. Interestingly enough, one does not encourage dedication by offering personal rewards. Churchill offered only blood, sweat and tears, yet he elicited one of the greatest outpourings of dedication in history. To elicit dedication it is not necessary to offer gross rewards. But dedication is not inspired by downgrading the employee's contribution, either. The problem is to let even the humblest employee see how his small work fits into the total pattern. This is a much neglected aspect of executive control. When the employee sees how his labors are essential to the organization, he acquires pride in it. The operating phrase is "see how".

There is much talk of idealism in the executive function, particularly in the health and welfare field. But the successful executive has to be only a *limited* idealist. He has to have his sights high but he should not aim at the North Star. Firmness is not a synonym for pigheadedness.

The executive must be discreet. This is hard to do. Since knowledge is power, anybody who has the knowledge may be greatly tempted to talk about it and thus exhibit his power. When he tells it, he has spent that fund. He needs to keep a reserve in that bank, and he must not dissipate it.

TO CITE OR NOT TO CITE REASONS

An everyday problem for the executive is whether to give reasons for a decision. One school of thought holds that the way to treat the subordinate is to say: "I want this." If he asks why, bark back: "Because I say so."

Another school of thought argues that the average intelligent person has a right to know why he must do things. In my earlier days, I shared this attitude. Soon I found out that when I started giving reasons, I opened the door to argument. A subordinate could then cite reasons on the other side; or he could challenge my facts. This would loosen executive control. I can now understand the position of those executives who find it easier not to give any reasons but, in effect, make a command decision.

It is possible to tell a member of your staff that you are going to make a decision for reasons you think best without sounding whimsical or arbitrary. The way to do it, it seems to me, is this: "Well, I have listened to your reasons and what you say does make sense, and you certainly have a point. However, there are equally cogent reasons on the other side, and somebody has to make the decision. That is my responsibility and, therefore, I have decided that we will do XYZ."

Since any intelligent person can think up reasons to justify his wants, the executive who gives reasons to a subordinate never actually convinces him. All he does is give him ammunition. If, by sheer authority, the subordinate is made to say "uncle" and to agree, this is only sham democracy. The reasonableness is phony.

A subordinate feels better if he is ordered to do something against his judgment than if he is sweet-talked into it. In the first instance he can find an outlet in grumbling, and he can always divest himself of any responsibility. On the other hand, if he is coaxed into consenting, his position becomes much less satisfactory. This leads to the unpalatable conclusion that it is often better not to give reasons for certain decisions.

Courtesy to a senior department head requires that he not be sent a written order adversely affecting his department without his having been given an opportunity to discuss it. But this does not mean that he has to be given all the reasons behind the order. In such a case, the executive may find himself in the position of choosing between doing something he cannot defend or reversing himself at the sugges-

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—Comments on cleanliness

Hospitals must be maintained to insure the safety of patients. The physical plant must be kept clean and in good repair, and every department should cooperate and participate in keeping the hospital environment clean and safe. Apparently some laxity in this regard prompted Kenneth B. Babcock, M.D., director, Joint Commission on Accreditation of Hospitals (JCAH), to comment thus in the August 1961 issue of the Bulletin of the JCAH.

Surveyors of the JCAH report that standards of cleanliness are often poorest in the following areas:

1. Ventilation and air conditioning systems. Regular inspection and cleaning of air intake sources, screens and filters should be done. Special attention should be given to high-risk areas, such as operating rooms and nurseries.

2. Bathrooms and lavatories. Soiled wash basins and littered floors are both unattractive and unsafe.

3. Water carafes. Use of difficult-to-clean water carafes should be avoided.

4. Utility rooms. Facilities for the disposal of excreta and sterilization of bed pans need special attention.

5. Kitchens and dish washing facilities.

6. Laundries. Proper facilities and techniques for handling contaminated linen should be established.

7. Corridors. These should be clear and unobstructed; not an obstacle course of stretchers, wheel chairs and utility tables.

A safe, clean hospital requires the constant vigilance of every physician, nurse and hospital employee. ■

tion of the subordinate. If he makes the decision, gives the reasons, and is then talked out of it, he loses face and acquires a reputation for indecisiveness.

RAGE, DON'T WHINE

What about the executive's own grievances? In airing a grievance of his own, the boss does better to rage than to whine. You might think that displays of bad temper would be harmful to an administrator's career. Actually, they are less harmful than whining or complaining. Most people have a sneaking admiration for an episode of violent temper. Adjectives like "magnificent" are often applied to outbursts. The staff considers a low temper threshold and a high potential for irritability to be the attributes of a good executive.

The most effective course is to earn a reputation for being even-tempered and for rarely going into a rage. As a result, subordinates and staff will say with pride: "He seldom loses his temper; but when he does, watch out!" By definition, temper is unreasonable; still there is a certain margin of control here, and the shrewd executive keeps reins on it. He wants to be considered a big man. Big men may blow off steam through displays of violent rage, but big men do not whine.

When an administrator has been with an organization a long time, he has many personal contacts with those in the lower ranks. The tendency is to bypass the intermediate supervisors and make direct contact with these persons. This looks democratic, and some superintendents are proud of the fact that they don't go through channels or that they cut red tape. However, going through channels has developed out of wisdom and experience. Bypassing the supervisor in the middle causes him to lose face. To short-cut the channels may give the executive an illusion of swift efficiency, but the gain in speed is more than offset by the loss of morale.

An executive cannot afford to be vengeful. It is folly to convert a casual dissenter into a sworn enemy, and this happens when a feud arises. If the administrator must hurt an employee, he should try to neutralize the hurt with a favor. If that is not possible, he should neutralize the hurt with some degree of amiability. To carry on a vendetta is to court disaster. Any employee may have powerful connections or may become the nucleus of a strong mutinous movement. The wise executive says to himself: "I will not humiliate anyone; I will not seek revenge; I will not try to teach any opponent a lesson, for in such a school, it is the teacher who pays the tuition fee."

One of the executive's prime problems is how to delegate authority. If he keeps too many strings in his own hands, the subordinates think they are playing the role of office boys. Spending too much time on details crowds out the more important public relations aspect of the executive's work. He sacrifices strategy for tactics. But if he delegates too much, he binds himself to the decisions of a bungling subordinate, and runs into the danger of not knowing the score. The wise executive errs—if he must err—on the side of delegating too little rather than too much. If he delegates too little, he may be damaged by overwork. But he can be more severely hurt by the mistakes of an unsupervised subordinate or by things that happen without his knowing about them.

PROFILE OF A GOOD EXECUTIVE

In summary, let me draw the profile of the good executive. His qualities may be grouped into three areas: physical, social and psychological.

Physical: The good administrator must appear to have a good deal of energy. He may actually be tormented by ulcers or live in dread of a coronary. Perhaps, to preserve his heart, he uses the elevator to go down one flight. But he must not wear his invalidism where all can see it. He should have a good sick-leave record. His height and weight do not matter, but his general physical appearance does. He cannot afford to look slovenly. During meetings he cannot doze off. No matter how boring the session, he must learn how to remain awake, or at least how to look as if he is awake.

Social: It is in his relations with others that the executive is tested. He must be comfortable with people. If he isn't, he will try to administer his organization by remote control, depending either on department heads whom he can't supervise or on written memoranda which lack plasticity. Because the good executive is comfortable with people, he has a basic amiability, a trait that in another setting might be called kindness. When he can say "yes" without demoralizing others or hurting his program, he says "yes". While he likes people, he is not neurotically dependent on them. On the contrary, he is able to tolerate some degree of isolation and some degree of hostility. He has accepted the fact that he can't please everybody and is willing, therefore, to displease some even if it means making enemies. He supports his subordinates even when they're wrong.

Psychological: The good executive has zest. He likes his work and thinks that what his organization is doing is really important. He has several kinds of courage: the courage to resist outside pressures; the courage to draw hostility to himself; the courage to do an unpleasant job without too much anxiety; the courage to make firm decisions even though he is not sure he is 100 per cent right. And he has a good opinion of himself. High self-esteem is essential to winning the esteem of others. This sometimes makes for arrogance; if so, this is the lesser evil.

Admittedly the executive's is a tough life with back-breaking responsibilities and a high ulcer rate. For the role he has to be curiously constructed. He must have a chin flexible enough to be stuck out all the time and firm enough to "take it". He must have one hand on the reins, and one foot always in the door. His heart must be both big and in the right place. He needs a back like a pin-cushion because knives will sometimes be stuck into it. Like a contortionist, he must stand on his own two feet while keeping his shoulder to the wheel, his eyes on the stars and his head on his shoulders. He must have lots of stamina and a stomach strong enough to swallow anything.

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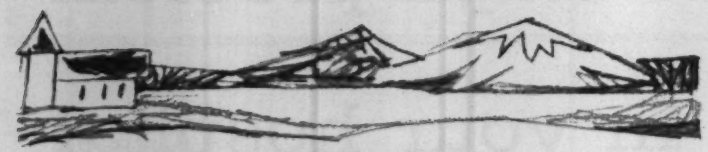

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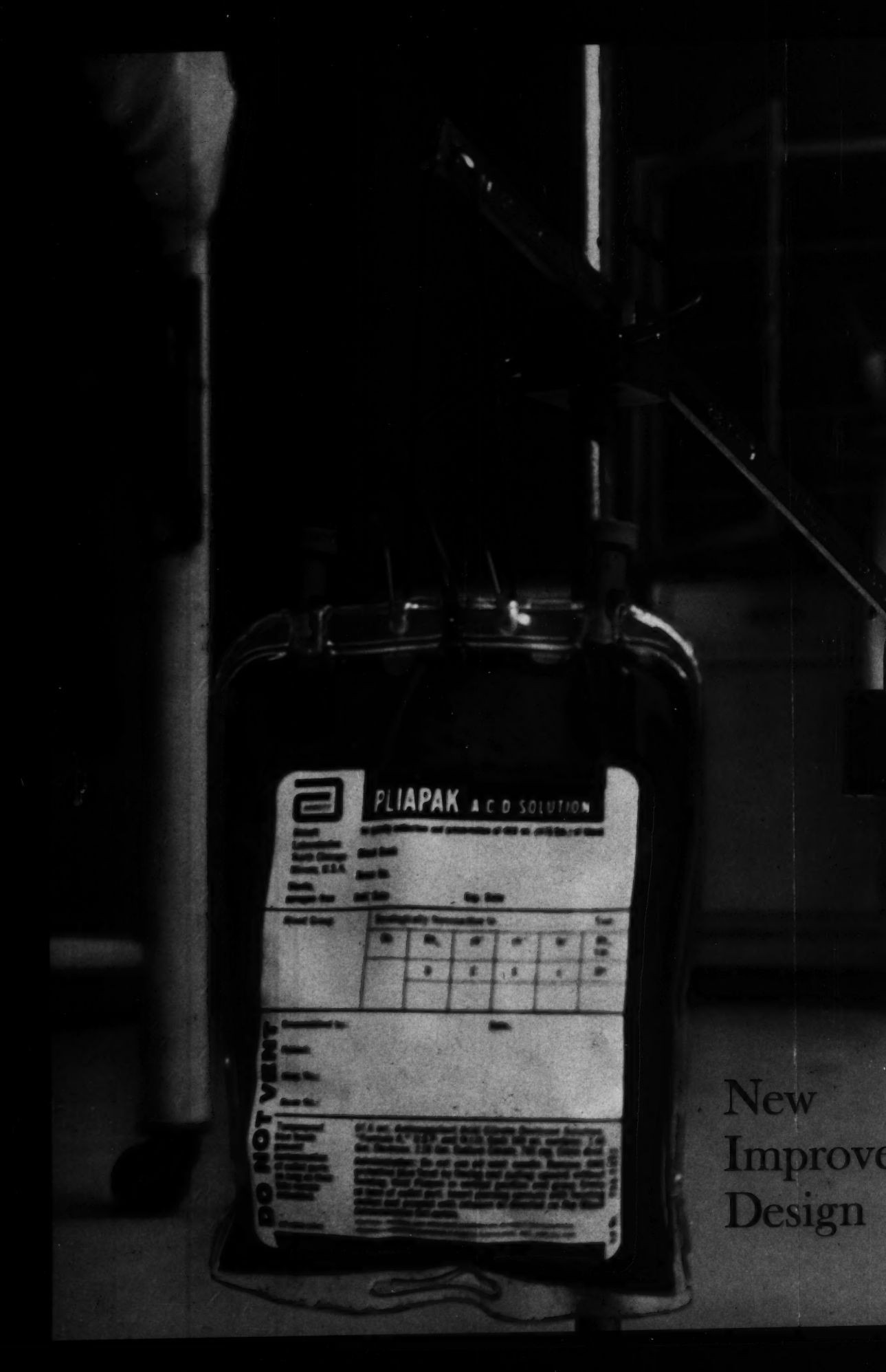
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PLASTIC AND GLASS CONTAINERS IN BLOOD BANKING: SOME PRACTICAL CONSIDERATIONS

by LLOYD R. NEWHOUSER, M.D.

The use of plastic blood bank equipment is gaining momentum and may eventually replace the glass container in transfusion therapy, according to the author. He also discusses the advantages and disadvantages of both glass and plastic transfusion equipment.

THE WIDE and preferred acceptance of plastic equipment rather than glass for use in blood banks during the last few years has made it almost imperative that the hospital administrator be well versed in the relative merits of each. Some members of his staff will want plastic equipment for use in the hospital blood bank while others may insist on the use of glass containers. Still others will have little or no preference as to the type of equipment used.

The entire staff, however, will be interested in the quality of the blood used and its compatibility with that of the patient. Precise techniques in the collection, storage and crossmatching of blood are paramount in blood banking. The highest degree of technical skill, the safest transfusion equipment and the most accurate records possible differentiate the outstanding blood bank from the mediocre one. These characteristics are deterrents to transfusion liability suits.[1-3]

This wide acceptance of plastic has been accelerated by the availability of a complete line of better plastic equipment, which meets the needs of the blood bank and the medical staff.

Following are some advantages and disadvantages of plastic and glass transfusion equipment.

ADVANTAGES

PLASTIC EQUIPMENT

1. Freedom from hemolysis.
2. Ease of preparation and less danger of contamination when preparing cell mass and other blood components.
3. No danger of air embolism when giving pressure transfusion.
4. No venting during administration.
5. Minimal danger of contamination with integral donor tube.
6. Minimal danger of pilot tube errors in crossmatching when integral donor tube is used.
7. Better cell preservation in general.
8. Greater ease and safety in preparing and thawing fresh frozen plasma.
9. Increased ease and safety in doing plasmapheresis.
10. Ease of preparing platelet rich plasma and platelet concentrates in completely closed system.
11. Better logistics.

GLASS BOTTLES

1. Equipment fairly well standardized.
2. Smaller needle can be used with vacuum bottles.
3. Usually less indoctrination of personnel required.
4. Less cost.
5. Great production facilities (important in a national catastrophe or emergency).

DISADVANTAGES

PLASTIC CONTAINERS

1. May be punctured by sharp instruments.
2. Usually requires more indoctrination of personnel.
3. Little standardization of size and shape of containers.
4. Little standardization of recipient sets.

(Continued on page 125)

Lloyd R. Newhouser, M.D., is deputy national director, Blood Program, American National Red Cross, Washington, D.C. This paper reflects the personal views of the author and they should not be construed as representing official American National Red Cross policy.

5. Not too satisfactory for storing (aging) liquid plasma.
6. Possible shortage during a national catastrophe or emergency.
7. Larger donor needle required, unless special device is used in collection.

GLASS BOTTLES

1. Breakage.
2. Greater space required for storage and weight.
3. Greater danger of contamination and less ease in preparing blood for component therapy.
4. Possible air embolism (if air pressure is introduced into bottle).
5. Glass deleterious to cells unless properly siliconized.
6. Requires venting.

There may be those who will take exception to some of the advantages and disadvantages listed, but these are facts based on unprejudiced personal experience over a 10-year period.

GLASS VACUUM BOTTLES

Vacuum-type glass containers do tend to produce some hemolysis if care is not exercised in blood collection.[4] Containers should be inverted during the collection of blood (a) to prevent undue trauma to the cells; (b) to avoid possible air embolism should there be positive pressure in the bottle, and (c) to detect loss of vacuum through technical error just prior to venipuncture.

If there is partial or complete loss of vacuum and the donor exercises the forearm muscles during the collection of blood, the muscular pumping action on the veins may be sufficient to develop a positive pressure in the bottle. If the bottle is turned upright, after the collection of 300-400 ccs. of blood, without clamping the donor tube and the tourniquet is released, air will be expelled into the vein. Although this happens infrequently, it is alarming and dangerous when it does occur.[5]

The gravity-type silicone bottle is on a par with the plastic bag so far as hemolysis is concerned, unless the manufacturer fails to coat the entire inner surface of the silicone bottle. However, cell survival rates do not usually reach the level found with plastic bags.[6]

The majority of blood bank personnel who have used both plastic and glass containers will concur that cell mass, plasma, washed cells, platelet-rich plasma and platelet concentrates can be prepared with greater ease and less danger of contamination when using plastic containers. The availability of plastic equipment permits preparing these various blood components within a closed system.

Bottle breakage during centrifuging occurs occasionally, although it is unusual to observe fracturing or leakage of plastic containers during centrifuging unless sharp objects are present in the centrifuge cups. Plastic bags stand the rigors of high centrifugal forces better than glass bottles.

The flexibility of plastic plus the action of atmospheric pressure make venting of plastic bags unnecessary. Absence of need for venting also facilitates starting the transfusion because slight pressure can be exerted on the container to fill the transfusion set.

From the standpoint of logistics, plastic containers offer considerable advantage. They weigh less and require less storage area. Plastic bags can be stored for long periods without any effect on their usability,[7] which makes rotation of stock each year unnecessary, and permits establishment of large inventory for disaster purposes. Because of this and other advantages, the armed services standardized on plastic equipment several years ago.

Fresh blood usually tolerates transportation over great distances. However, this is not always so, especially when the blood is 12 or more days old and if it has been collected under vacuum in glass containers. Blood more than 10 days old withstands transportation better when collected and stored in plastic containers. There is less opportunity for turbulence of cells during transportation because of the absence of air space in the container.

Pressure transfusions can be given with dispatch when blood is stored in plastic containers. This may be accomplished by wrapping a sphygmomanometer cuff around the bag and inflating it to the desired pressure. Special devices are also manufactured for this purpose. Transfusions may be safely administered under pressure from glass containers by means of a hand-type transfusion set. This procedure, however, is fatiguing to the operator, especially if the intravenous needle is smaller than 18 gauge. Under no circumstances should a transfusion be given by forcing air into the bottle. To administer blood by this method is an open invitation to disaster from air embolism, followed by a liability suit.[8]

At the present time, there is comparatively little standardization of the size and shape of plastic containers, although some recipient sets can be used interchangeably in glass or plastic containers if proper caution is exercised. The glass equipment is standardized to the degree that all the blood bottles fit the standard centrifuge cup. The rubber stoppers used in the glass containers are similar, although not identical.

INDOCTRINATION OF PERSONNEL

The hospital staff should be thoroughly indoctrinated before making the transition from glass to plastic transfusion equipment. This indoctrination should be done by lecture and demonstration in the technique of collecting, processing, cross-matching and administering whole blood, cell mass, plasma and platelets. The greater portion of this indoctrination should be carried out by an experienced manufacturer's representative.

When plastic containers are used in the preparation of fresh frozen plasma, they should be placed in a thin cardboard container and frozen immediately. Thawing should be carried out by placing the entire package in a water bath at 37° C., which permits rapid thawing without danger of breakage. Occasionally breakage does occur with glass containers.

Cost should not be a deterring factor in blood collection and administration because quality is so important. It is well recognized that blood properly collected in approved plastic containers, or siliconized glass containers (gravity type), offer the blood bank and the patient a better quality of blood. Any small, additional cost need not

be passed on to the patient because it is offset by less blood being discarded as unfit for transfusion. ■

REFERENCES

1. Tuohy, E. K. Careless blood banking: a major cause of transfusion reaction. *N.Car.Med.J.* 40:4 April 1959.
2. Ross, J. B. Problems of blood group incompatibilities. *Am.Assoc. Blood Banks Bull.* 10:3 March 1957.
3. Editorial, Blood transfusions: medico-legal responsibilities. *J.A.M.A.* 163:4 Jan. 26, 1957.
4. Murphy, W. P. Jr. *et al.* Hemolysis in blood collected for plasma processing. *J.A.M.A.* 158:6 June 11, 1955.
5. Schmidt, P. J. and Kevy, S. V. Air embolism: a hazard during phlebotomy. *N.Eng.J.Med.* 258:9 Feb. 27, 1958.
6. Strumia, P. V. Effect of container, sugar concentration and temperature of storage on red cells. Address to Penna. Assoc. of Blood Banks. Oct. 7, 1960.
7. Walter, C. W. *et al.* Stability and quality of plastic transfusion equipment. *Surg., Gyn. and Obst.* 111:2 August 1960.
8. Ruesch, M. *et al.* Continuing hazard of air embolism during pressure transfusions. *J.A.M.A.* 172:14 April 2, 1960.

An action program for nursing education

by WILLIAM L. WILSON JR. and WILFRED A. POIRIER

A voluntary council on nursing education successfully conducted an action program to provide more professional and practical nurses for duty in New Hampshire, according to the authors. They also describe the formation and work of the council and the elements of the action program.

NEW HAMPSHIRE, in common with other areas of the country, has been faced with a shortage of nursing personnel—a problem which became acute immediately following World War II. The nursing education system, and nurses returning from military service, failed to produce the necessary number of trained professional nurses for hospital nursing service assignments, public health agencies and school nursing. In particular, a grave shortage occurred of qualified administrative and instructional personnel for leadership positions in education and nursing service.

ALERTING THE COMMUNITY

Among those who distinctly realized the problem was John McLane Jr., a Manchester attorney and a public spirited citizen with keen insight into the health field. Through the interest of Mr. McLane, the support of the Spaulding-Potter Charitable Trusts, established by the will of a former governor of New Hampshire, was obtained. The opinion of interested educators, nurses, hospital administrators, trustees, physicians and others was sought and a committee was formed to study nursing and nursing education in New Hampshire. Representation included one nurse from a collegiate nursing program; one nurse from a diploma nursing program; a hospital trustee; a hospital administrator; two practicing physicians, and the state commissioner of education. The group went to work as the Spaulding Committee on Nursing Education in the fall of 1957 and soon determined that there was a large job to be done.

In January 1958, the committee, granted sufficient funds to cover a two-year operating budget, engaged a qualified project director and went to work. Organizationally, the group functioned as a committee until December 1958 when it incorporated, under a nonprofit charter granted by New Hampshire, as the Spaulding Council on Nursing Education, Inc. The main purpose of incorporation was to permit the council to receive a further substantial grant from the Spaulding-Potter Charitable Trusts to continue what had become an extremely active program with great opportunities for constructive future work.

The early months of 1958 were spent studying all available data on nursing and nursing education in New Hampshire, surveying the extent of the nursing shortage in various categories and determining the apparent reasons and what directors of nursing service and nursing education, hospital administrators and others thought could be done to alleviate the situation.

Following the analysis of this and a vast amount of other data, the committee sponsored a statewide conference, in November 1958, to which were invited approximately 150 people representing nursing, medicine, hospitals, nursing homes, general education, legislative groups and the public. The purpose of the conference which proved extremely fruitful, was to provide an opportunity for all those invited to suggest to the committee specific areas of need toward which efforts could be devoted. At this point, the committee realized a real opportunity to continue its work. An action program was mapped out and the incorporation was accomplished.

ACTION PROGRAM ELEMENTS

From January 1959 until the present, the Spaulding Council on Nursing Education, Inc., has conducted this action program. A brief description of elements of the action program follows.

Extension Courses for Nursing Service Personnel. Working closely with the one collegiate program in nursing in the state, a traveling faculty made available extension courses for nurses employed in New Hampshire hospitals and nursing homes. These were two-credit courses, and they were offered in 10 locations throughout the state. Courses offered were the professional nurse in modern society, supervisory skills in nursing and principles of teaching, and 326 graduate nurses took advantage of this opportunity to acquire practical knowledge in

William L. Wilson Jr. is president, Spaulding Council on Nursing Education, Inc., and administrator of Mary Hitchcock Memorial Hospital, Hanover, N.H. Wilfred A. Poirier is project director, Spaulding Council on Nursing Education, Inc., Concord, N.H.

the field and collegiate credit at the same time.

Refresher Courses. Many registered nurses in New Hampshire are ready to return to active nursing, but are unfamiliar with changes in nursing service and techniques since they may last have been active in the profession. Therefore, a series of refresher courses have been sponsored as a means of encouraging inactive registered nurses to return to active duty. Also, in cooperation with the Department of Hospital Nursing Committee of the New Hampshire League for Nursing, the council has assisted in conducting 20-hour refresher courses for graduate professional nurses in several different geographic areas of the state.

Counsellor Conferences. Annually since the formation of the council, and again in cooperation with the New Hampshire League for Nursing and its careers committee, conferences on nursing have been held, to which high school counsellors and administrators are specifically invited. These conferences constitute an opportunity to provide persons in the secondary school system with an accurate and complete picture of nursing education in all its phases.

Extension Courses for Diploma School Faculty Members. In cooperation with the state league, extension courses have been made available to directors and members of the faculties of hospital schools of nursing. Courses have been made available at either the baccalaureate or master's level, and with council financing, a total of six credits is allowed to each interested individual. The council is also sponsoring a five-day institute for these persons on curriculum planning and clinical instruction.

Practical Nurse Education. This was one area of nursing education deemed to warrant primary attention. One independent program in a county hospital had been in existence for a few years, and at the time the council was formed, a second program was established. Other than this, there had been no activity in the education of qualified practical nurses in the entire state. The study findings of the council had indicated clearly the need for considerable numbers of well trained practical nurses, so with the fine cooperation of the Vocational Division of the New Hampshire State Department of Education, it was arranged to establish a new school of practical nursing. A grant was made by the council to the state department of education, which with matching federal grants will support this program during its formative years. It is expected that governmental funds will make continuation of this program possible.

School-of-Nursing Cost Study. Early findings confirmed the fact that hospital trustees and administrators, and to a degree nursing educators, have a deep concern over the growing hospital burden of supporting nursing education in diploma schools. This concern was somewhat academic because few, if any, hospitals conducting diploma schools of nursing were certain what the net cost was to them. The council, together with accounting specialists from the New Hampshire-Vermont Blue Cross and other interested organizations, sponsored conferences by which a uniform study throughout the state using the National League for Nursing "usability" method of calculating nursing student service time value was conducted. Now the hospitals of the state have a realistic basis for calculating the cost of nursing education.

New Programs in Professional Nursing. Council members shared the feeling that there was opportunity for a new and fresh look at certain elements of professional nurse education in the state. It was hoped that any venture into this realm would enlist state government support of education, with nursing education extended wherever possible by state and local governments. This conclusion, of course, was reached because of the desire to have the public share certain costs of education and nursing. This is a somewhat new, and as yet unaccepted, viewpoint in New Hampshire.

Miscellaneous Activities. The council has assisted a variety of activities by organizations with an interest in the nursing education field. The project director and council members have been called upon frequently to tell of the work of the council, and they have participated directly to a considerable degree in all the activities described.

The work of the Spaulding Council on Nursing Education, Inc., nears its probable termination, but certain conclusions have been reached. These are:

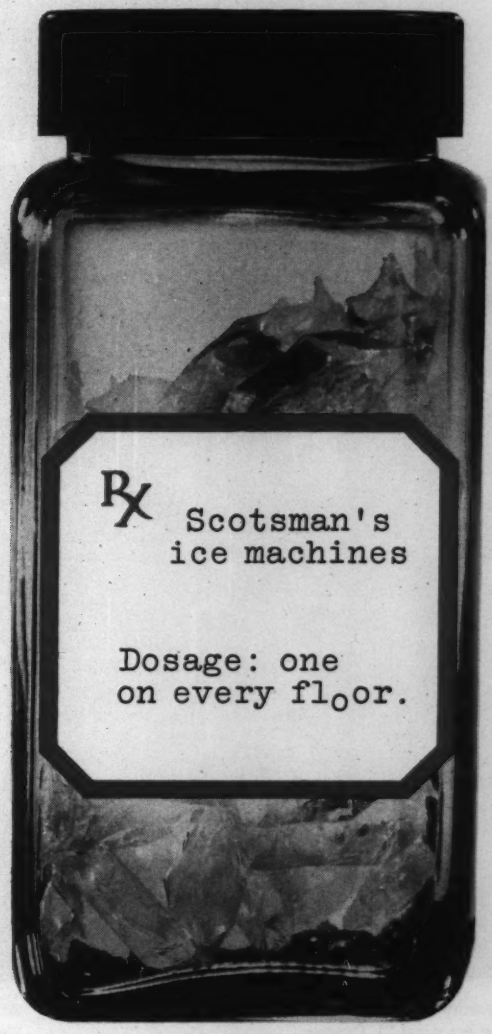
1. This is a fertile field for constructive collaborative effort. The fertility of the field may vary according to area. In some areas much has been done, and in others, even less than in New Hampshire.

2. Funds for the conduct of any such study and a follow-up program are invaluable. All the work in this area previously done by volunteers has been well-meaning but uncoordinated, and has suffered from lack of follow-up. Funds not only permitted the employment of a qualified project director, but also allowed the allocation of funds in substantial amounts to certain projects undertaken. This should not be considered essential to an active program of this sort.

3. Appointment of the council members on an individual basis, with no direct allegiance to organizations or other interests involved, permitted maximum objectivity and made for harmony within a group where vested interests could well have been less than constructive. This same factor enabled interorganization cooperation to a degree previously thought impossible.

The year 1961 will probably mark the end of the council's existence. Funds are running out, and it is quite frankly thought that a group of this sort has done about all it can up to this point. The sincere hope is that the final report of the council, which is to be distributed to all individuals and groups in any way concerned with the work undertaken, will point the way toward continued collaborative action of a constructive nature on a continuing basis.

Although there is no thought that magic answers have been produced, it is confidently believed that real contributions have been made to the field of nursing education by the council and that a stimulus has been provided for continuing future activity by other permanently established groups or agencies. ■



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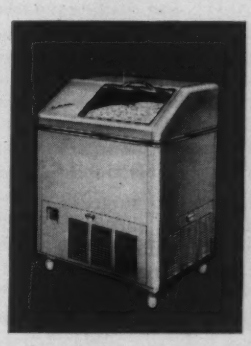

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References: 1. Fell, E. H.: *Am. J. Surg.* 99:265, March, 1960. 2. Bettley, F. R.: *Brit. M.J.* 1.1675, June 4, 1960. 3. Hardyment, A. F.; Wilson, R. A.; Cockcroft, W., and Johnson, Betty: *Pediatrics* 25:907, May (Pt.II), 1960. 4. Editorial, *Canad. M.A.J.* 83:1112, Nov. 19, 1960. 5. Valentin, Hans: *Med. Welt* No. 2:121, Jan. 9, 1960. 6. Hill, A. M.; Butler, H. M., and Laver, J. A.: *M. J. Australia* 2:633, Oct. 31, 1959.

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FIRST OF THREE ARTICLES

Contemporary Hospital Pharmacy—

its origin and evolution as a specialty

by ROBERT P. FISCHELIS, Pharm.D., Sc.D.

In this article, the first of three on the subject of contemporary hospital pharmacy, the author discusses the origin of this specialty, its growth in the last decade, the significant contributions of its members to pharmacy generally and its specialized functions.

The second article, which will appear in the November 16 issue of this Journal, will critically review the current status of the entire field and will discuss some of the problems which hospital pharmacy must solve to continue its professional growth.

The third article, which will appear in the December 16 issue of this Journal, will analyze forces and trends working presently in the field and will attempt to point out the directions in which these may take hospital pharmacy, with emphasis on their implications for good hospital pharmacy practice in the future.

PHARMACEUTICAL service in hospitals is as old as hospital service itself. Pharmacists who practice their profession in hospitals were not trained originally as specialists. They adapted themselves to the environment in which they worked. Until the advent of mass production of pharmaceuticals, the manufacture, compounding and dispensing of drugs was not much different in a hospital pharmacy than in a community pharmacy.

With the evolution of manufacturing pharmacy as a specialized function of the practice of pharmacy, the compounding function left the community pharmacy much more rapidly than the hospital pharmacy. As a matter of fact, while the number of compounded prescriptions in the average community pharmacy is probably less than 10 per cent of the total, the larger hospital pharmacies, and many of the smaller ones also, still do considerable compounding as well as bulk manufacturing and, in some cases, prepare their own parenteral solutions and manufacture other pharmaceuticals.

The larger hospitals have always carried on enough pharmaceutical activity to warrant the employment of a full-time pharmacist. Smaller units depended upon part-time or neighborhood pharmacists to supply services which could not be taken care of by nurses or medical interns.

When one delves into the history of pharmacy and tries to locate specific instances of outstanding contributions to the practice of the profession in hospitals, there are relatively few such instances in the records. However, in the early years of the current century, there are records of outstanding contributions by hospital pharmacists to the literature of pharmacy and to the development of new drugs and more convenient dosage forms. The most outstanding contributions are in the field of formularies. Charles Rice, a hospital pharmacist, was the chairman of the committee which produced the first edition of the National Formulary of the United States (1888).

One of the advantages of a well-equipped hospital pharmacy and a highly competent hospital pharmacist is the opportunity thus provided to the medical staff to obtain, rather promptly, a dosage form of some drug which may be required to fit the treatment of an unusual

Robert P. Fischelis, Pharm.D., Sc.D., is a pharmacy consultant in Washington, D.C.

case. One of the reasons why there has not been a greater continuing development of special formulas by hospital pharmacists is that the expansion of hospitals has coincided in considerable measure with the expansion of the drug industry and the growth of competitive industry research has stimulated a high rate of new product development.

SPECIALIZED FUNCTIONS

Within the past century, drug manufacturing as a specialty has gradually superseded compounding in the individual pharmacies to such an extent that the applied research and development facilities of the drug industry have far outstripped those of the colleges of pharmacy and private laboratories attached to community pharmacies. Quite a number of our older drug manufacturing houses are outgrowths of community pharmacies which developed their manufacturing activity to the point of servicing other community pharmacies more interested in merchandizing commodities related or unrelated to drugs than in drug manufacture.

Today, we speak of the practice of pharmacy in terms of several specialized functions. Probably 80 per cent of the pharmacists of the United States are engaged in the practice of pharmacy either as owners or employees, in establishments usually referred to as community pharmacies, retail drugstores, or prescription shops, depending upon the emphasis which the owner places on the services rendered.

Those who operate in transient metropolitan areas and do what is referred to as a "general drug business" usually concentrate their efforts on vending fast-selling, advertised remedies for self-medication, cosmetics, sundries, tobacco, confectionery and many related and unrelated items of merchandise. Most of these establishments also have a soda fountain and serve food. In such establishments the pharmaceutical service is usually confined to prescriptions which are easily dispensed and no pretense is made of giving what may be referred to as a complete pharmaceutical service.

(Continued on page 78)

HOSPITAL PHARMACY GROWTH

The pharmaceutical survey carried on during 1946-49 under the auspices of the American Council on Education, financed by the American Foundation for Pharmaceutical Education and directed by the late Dr. Edward C. Elliott, at that time retiring president of Purdue University, included the following brief but potent reference to "hospital pharmacy practice":

"The pharmacist engaged in hospital practice," says the report, which was published a little more than 10 years ago, "holds a most, if not the most, strategic and important position in the entire field of professional practice. By virtue of the environment in which he practices, demands are made upon his professional and personal abilities, which indeed represent a challenge. The proper discharge of his duties, as well as his success in what is a vital public relations responsibility, affect not only his hospital, its patients and staff, but reflect sharply on the profession outside the hospital's walls.

"The daily contact with physicians, and particularly with young physicians, gives him an unequalled opportunity to provide professional assistance and to furnish information without bias concerning drugs and drug preparations."

Statistically, this survey reported, "It is probable that the number of pharmacists now (1949) in hospital practice is close to 3000. Approximately 41 per cent of the hospitals in the United States have pharmacy departments, according to the 1949 Directory of the American Hospital Association. Of the 6160 hospitals reporting, 2737 indicated that they have a pharmacy. This is a two per cent increase over the number of hospital pharmacies reported for the previous year.

"According to the report on hospitals in the general and special short-term classification, almost all hospitals with more than 250 beds have a pharmacy; a pharmacy department is reported for 76.1 per cent of the hospitals in the 100-249 bed size, in 31.67 per cent of the hospitals having 50-99 beds and 16.6 per cent of those under 50 beds.

"In the long-term hospitals, 42.8 per cent were reported as having a pharmacy, and 86 per cent of the federal hospitals have a pharmacy.

"Although 2737 pharmacies are reported in the hospitals in the United States, this is no indication of the number of hospital pharmacists practicing since some hospitals do have more than one pharmacist."

More recently (1960), there has become available a body of information through the audit of pharmaceutical service in hospitals, conducted under a National Institutes of Health grant by Don E. Francke, Sc.D.,* from which the following data are taken:

"A total of 5833 pharmacists were employed in all of the nation's hospitals in 1957. [This is about double the number reported in 1949.]

"Approximately 86 per cent of all short-term hospitals over 100 beds employed a pharmacist on a full-time or part-time basis in 1957.

"More than 10,000 pharmacists will be in hospital practice by 1975 according to manpower studies carried out as part of the audit. This is almost double the number practicing in this specialty in 1957."

*Director of Pharmaceutical Service, University Hospital, Ann Arbor, Mich.

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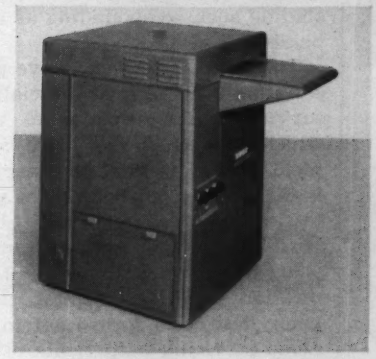

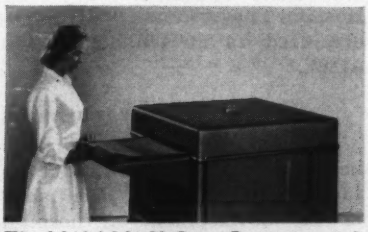

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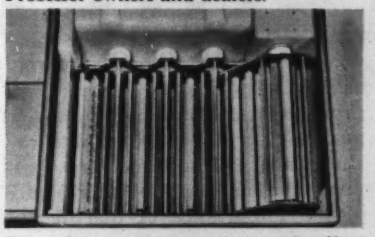

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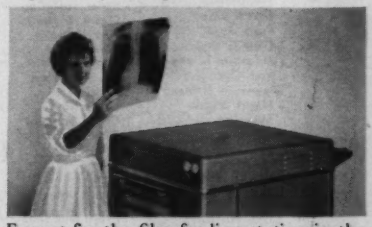

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The more or less exclusive prescription shop offers a specialized service which approaches that which is given in the more complete type of hospital pharmacy. It is the latter group within the profession which is concerned about possible competition from hospital pharmacies, when there is an indication that the hospital pharmacy desires to spread out to include servicing outpatients of the hospital, or those who are private patients of members of the hospital staff.

It is also this group that is most apt to keep itself thoroughly informed on new drugs. Although it does not have the opportunity of personal contact with physicians to the same extent as the hospital pharmacist in his daily work, it is more likely to be consulted on the properties and dosage of and other information about drugs by physicians than the more commercially minded group.

When more hospitals felt the need of adding a full-time pharmacist to the staff, a movement which gained emphasis about 25 years ago, it was logical for those who had decided to make a career of hospital pharmacy to try to improve the professional status of pharmacy within the hospital organization. At the same time, hospital administrators became aware of the importance of placing the procurement and dispensing of drugs on a more businesslike basis. There was not sufficient time in the hospital administrator's day to interview representatives of manufacturing houses who had new products or "special deals" to advance, nor did they have sufficient knowledge of the specialized function of pharmacy to fully appreciate how to make this professional function an asset of considerable value to the institution.

The pressures resulting from such a situation caused administrators to include pharmacy service in their conferences with other administrators and in programs of meetings. In turn, the pharmacists involved began to grope for sources of information and help toward a better organization of hospital pharmacy facilities. The American Hospital Association, in 1935, acted to authorize its president to appoint a committee to study the operation of the hospital pharmacy and to develop minimum standards for hospital pharmacies "for the guidance of the hospital field". This was the beginning of establishment of pharmacy internships, pharmacy and therapeutics committees and progressive measures which have become standard procedures.

The records of the American Pharmaceutical Association (APhA) also show that in the late 1930's and early 1940's, there was considerable agitation for the establishment of a hospital pharmacy macy section. This was followed by conferences of hospital pharmacists whenever opportunities were afforded by conventions and other meetings of pharmacists. Finally, in 1942, the American Society of Hospital Pharmacists (ASHP) was organized as an affiliate of the APhA.

RAPID STRIDES

Readers of this Journal have been kept pretty well aware of the rapid strides that have been made in the development of hospital pharmacy in the last two decades. It is only necessary to call attention to the frequent publication of articles dealing with various phases of the practice of pharmacy as applied to hospital service, and the rather unusual development of the ASHP as an autonomous group under the wing of the APhA and the establishment of the *American Journal of Hospital Pharmacy.*

The audit of pharmaceutical service in hospitals (see box, page 76) cites the following rather interesting developments among others, which can be attributed very largely to the initiative of hospital pharmacists and the opportunity to exercise that initiative provided by hospital administrators:

Hospital pharmacists throughout the nation filled approximately 164 million prescriptions in 1956, amounting to $321 million worth of drugs. In addition, more than

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80 million orders for drugs to be administered to patients were dispensed to clinics and nursing units in hospitals. In dollar value, this is more than 27 per cent of all prescription drugs produced in the United States.

More than 26 million prescriptions were dispensed to outpatients by hospital pharmacists in 1956. These were dispensed through only approximately one-half of the nation's hospitals. In general, such service is offered through the larger institutions. Significant is the fact that nearly 50 per cent of the outpatient prescriptions filled by hospital pharmacists are supplied to indigent or partially indigent patients. Approximately 30 per cent of the outpatient prescriptions are filled for private pay patients, and around 20 per cent are furnished to others. It is believed that few hospital pharmacies in the United States provide prescription service for the general public.

CHIEF PHARMACIST DUTIES

Approximately 41 per cent of the hospitals in the United States having a pharmacy department operate a manufacturing or bulk compounding program. Approximately one out of four chief pharmacists is engaged in teaching activities in addition to other departmental functions. Almost six out of 10 chief pharmacists have opportunities to work out dosage forms for pharmaceutical preparations not available, while more than four in 10 have opportunities to carry out projects to extend and improve certain phases of pharmacy service.

A number of chief pharmacists are responsible for other hospital functions in addition to pharmacy. Approximately one pharmacist in five serves also as a hospital purchasing agent, while one in 20 is responsible for central sterile supply service and for central stores. At least 85 per cent of chief pharmacists have authority to list acceptable sources of supply for drugs purchased for use in their hospitals.

The $321 million spent by hospitals for pharmaceuticals in 1956 represent 15.5 per cent of the hospital's commodity budget. The average drug inventory per bed ranges from $63.66 in hospitals with 400 to 499 beds to $311.09 in hospitals with less than 50 beds. Thus, the average drug inventory per bed decreases as the size of the hospital increases.

The rate of annual turnover of drug stock or inventory in hospitals ranges from one to more than six times a year. About 50 per cent of hospitals have a drug stock turnover rate of three or four times a year, and 33 per cent have a turnover rate of five or more times a year. Nineteen per cent of hospitals have a turnover rate of only one or two times a year.

A high percentage of all pharmacists practicing in hospitals are young, from 20 to 40 years of age. The ratio of men to women in hospital pharmacy is two to one, with more than half of the women being members of religious orders. More women than men practice on a part-time basis and more women serve as staff pharmacists rather than as chief pharmacists.

The past quarter century has also witnessed a considerable advance in the educational program for pharmacists, and recent developments have improved opportunity for specialization. The present five-year program for the undergraduate degree in pharmacy includes foundational courses in the basic sciences and humanities as a preparation for the professional subjects. There is some opportunity for the selection of electives, and more colleges of pharmacy are providing for courses in hospital pharmacy as electives. There are also combinations of internships in university hospitals with academic work leading to a master's degree in hospital pharmacy.

The minimum standards for pharmacies in hospitals and the standards for approved hospital pharmacy internships developed by the ASHP, and recognized by accrediting agencies as well as the hospital associations, have gone far toward making competent persons available to direct hospital pharmacy activities in larger institutions.

The annual institutes in hospital pharmacy which have been fostered by the American Hospital Association have done much to supply continuing education for hospital pharmacists and to stimulate participation in discussion of management problems as well as in presenting and acquiring new information with respect to the administration of drugs.

The extent to which automation, in the discharge of routine functions connected with drug administration, will affect the practice of pharmacy in hospitals is a problem that is now engaging the attention of hospital pharmacists. Exploration of this development by leaders in the field seems to be called for to make sure that there is adequate protection of the patient and that the servicing of potent remedies in this fashion does not act as a damper on the ardor of a professional group which has made great progress because of an inherent desire to stress its personal service. ■

NOTES AND COMMENT

Drug Use in Public Medical Care Programs

Of interest to hospitals is the recent resolution by the American Public Health Association regarding the use of drugs in publicly administered health programs. This resolution, titled *Adequacy and Economy in the Use of Drugs in Public Medical Care Programs,* reads as follows:

"Whereas, the expenditures for drugs in public medical care programs frequently equal and occasionally exceed the expenditures for physician services, and *whereas,* surveys in such programs have indicated extensive use of non-specific drugs and unnecessarily high expenditures resulting from prescription of drugs by trade or proprietary names instead of by nonproprietary or generic names, therefore be it *resolved,* that the American Public Health Association encourage administrators of public medical care programs to seek the cooperation of the medical and pharmaceutical professions in reviewing policies and practices in the prescription and provision of drugs, in order to assure that only therapeutically effective drugs in appropriate amounts and at the lowest practical cost be made available to persons under care, and be it further *resolved,*

(Continued on page 126)

book reviews

also:
Army medical statistics
Planning through accounting
Obstetrical nursing techniques
Maintenance techniques
On improving nursing homes

New work on hospital infections

HOSPITAL INFECTION: CAUSES AND PREVENTION. R. E. O. Williams, R. Blowers, L. P. Garrod, and R. A. Shooter. Year Book Publishers, Inc., 200 E. Illinois St., Chicago, 1960. 307 pp. $7.50.

The distinguished authors of *Hospital Infection: Causes and Prevention* have written a valuable book that should be widely read by everyone concerned with hospitalized patients, from medical and nursing students, physicians and nurses through the senior and administrative staff. They have combined the results of their own comprehensive investigations with a selection of reports from other investigators into one of the most important publications to be prepared in this field.

The subject is divided into epidemiological considerations, with equal emphasis upon staphylococcal diseases and other hospital acquired infections including gastrointestinal and urinary tract infections, tetanus and gas gangrene, and diseases caused by hemolytic streptococci and by various viruses. There is a short but concise discussion of general factors that influence the development of infections.

The second section deals with the control of hospital infection, discussing the administrative and surveillance aspects of control, hospital design, general control measures, use of antibiotics, and sterilization and disinfection by heat and chemicals. An outline of methods for investigating epidemics is followed by a brief discussion of special technical methods with application in these studies.

All in all, a complicated and belabored subject has been reviewed and summarized in a comprehensive and readable manner, with proper emphasis upon facts and upon areas in which further investigation is sorely needed. The omission of details, unless they are factual or pertinent, adds to the usefulness of the book. As the authors point out in the preface, they "may be accused of too agnostic an attitude," but this is a desired and a rare quality for which they should be commended. Each chapter is followed by a list of selective references, mostly British.

The term "hospital infection" has a connotation today of staphylococcal disease only and it is refreshing to see the degree of emphasis that is placed upon the other infectious disease problems that continue to be prevalent in most hospitals.

One point of minor importance relative to fluorescent antibody staining materials should be made: contrary to what the authors state on page 291, the enteropathogenic *E. coli* fluorescent antibody preparation has been shown to be more specific than the group A streptococci preparation.

A more serious criticism is the index, which is inadequate compared to the standards set by the rest of this informative book.—PHILIP S. BRACHMAN, M.D., *chief, Investigations Section, Epidemiology Branch, Communicable Disease Center, U.S. Public Health Service, Department of Health, Education, and Welfare, Atlanta, Ga.*

Army medical statistics

TABULATING EQUIPMENT AND ARMY MEDICAL STATISTICS. Albert G. Love, Eugene L. Hamilton and Ida L. Hellman. Washington, D.C., Government Printing Office, 1958. 202 pp. $2.

The medical statistics program of the United States Army has had considerable effect on statistical programs and policies throughout the United States. This monograph, *Tabulating Equipment and Army Medical Statistics,* was co-authored by General Love, Office of the Surgeon General, who has had more experience in this field than anyone else. Tracing the development of medical statistical records for the U.S. Army, the authors show how medical records developed in response to specific needs. They also report how modern tabulating equipment was first used experimentally by the Surgeon General's office to process medical records.

General Love recounts his experiences with Herman Hollerith, M.D., in a most interesting and intimate fashion. Dr. Hollerith's association with the Bureau of the Census and the Office of the Surgeon General are intertwined with the development of the International Business Machines Corporation, in this monograph.

The volume also contains a fascinating history of the formation and growth of the Office of the Surgeon General of the U.S. Army.

The authors discuss in detail many medical records and describe their uses. The embodiment of their experience in this publication will be invaluable to anyone interested in medical statistics, and will give him considerable background for his present and future work in this field.

The authors are to be congratulated for writing so interestingly and helpfully on the development of medical records and records systems, with which they were so closely identified personally.

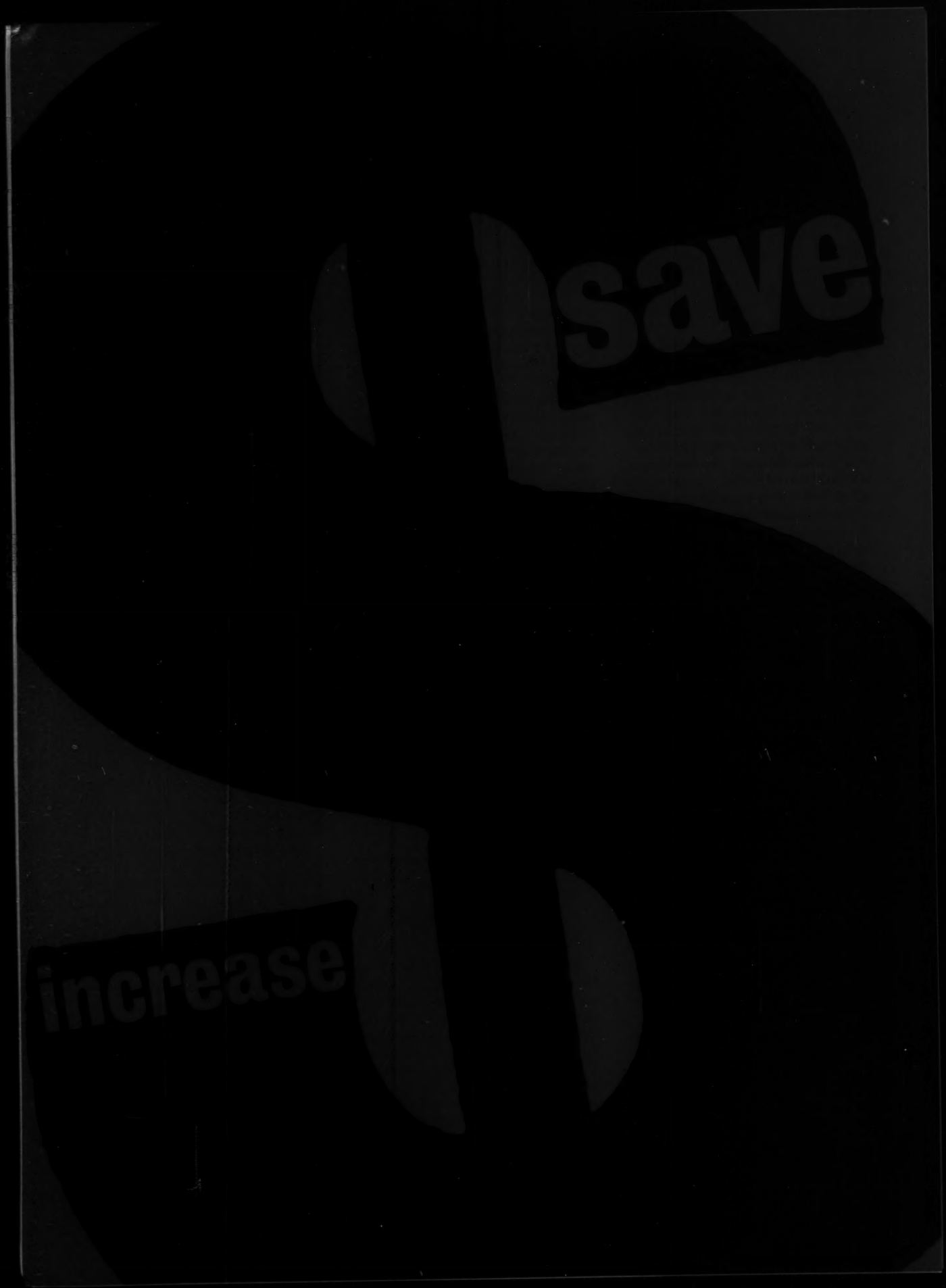
This monograph is recommended as an informative history of the Office of the Surgeon General of the U.S. Army, the development of the medical records of the Army and the adaptation of tabulating equipment to handle large volumes of records efficiently.—SCHUYLER G. KOHL, M.D., *associate professor of obstetrics, State University of New York Downstate Medical Center, Brooklyn.*

Planning through accounting

GUIDES TO HOSPITAL ADMINISTRATIVE PLANNING AND CONTROL THROUGH ACCOUNTING. Catholic Hospital Association. St. Louis, the Association, 1961. 57 pp. $2.

In its 57 pages this publication contains a logical presentation of

(Continued on page 95)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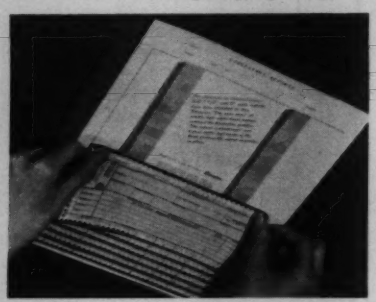
equipment and supply review

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

Medical records system (20F-1)

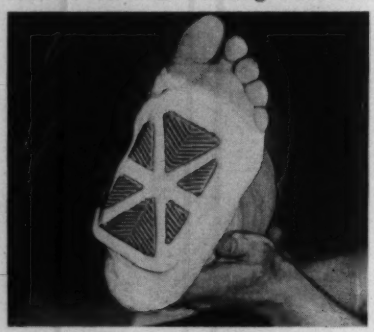
Manufacturer's description: This method of mounting hospital laboratory reports on patients' charts eliminates the need for stapling, gluing, or



taping. To mount a report, two raised tabs are removed exposing a pressure-sensitive adhesive, which can simply be pressed into place. *Beekley Corp., Dept. H20, West Hartford, Conn.*

Cast cushion walking heels (20F-2)

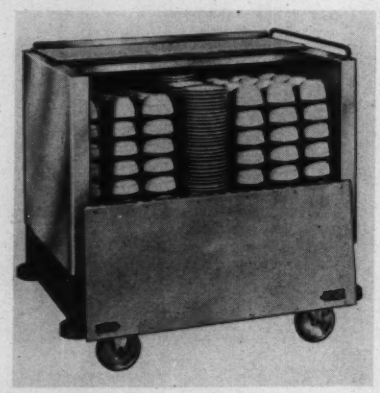
Manufacturer's description: A principal feature of this walking heel for



ambulatory cast patients is that it is lower in height, thus reducing the possibility of a forced limp. The cast cushion has a wide base and can be anchored securely by means of a deep criss-cross section spacing that permits the plaster bandage to be applied in a normal figure eight wrapping. Provided with a special tread to prevent slipping, the walking heel is molded of flexible, shock absorbing, resilient rubber and furnishes raised tips firmly set on the inner side of the heel cast to prevent lateral movement. *DePuy Mfg. Co., Inc., Dept. H20, Warsaw, Ind.*

Food service equipment (20F-3)

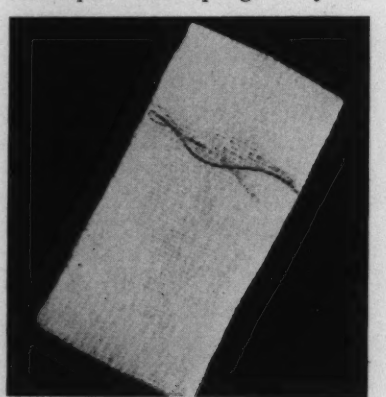
Manufacturer's description: Made of stainless steel and featuring removable plastic-coated shelves and partitions, this large capacity food server can transport and dispense 960 plates and 1000 pieces of silverware. All units are furnished with circular rubber bumpers, ball-bearing casters and 5-in. diameter metal wheels with replace-



able rubber tires. *W. H. Frick, Inc., Dept. H20, 704 Citizens Bldg., Cleveland 14.*

Surgical sponges (20F-4)

Manufacturer's description: This detectable strip sponge, in 2 by 4-in ply, eliminates the refolding of sponges for surgeons using the strip sponge technique. The sponge may be



▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____Medical records system (20F-1)
_____Cast cushion walking heels (20F-2)
_____Food service equipment (20F-3)
_____Surgical sponges (20F-4)
_____Head halter (20F-5)
_____Oval brush (20F-6)
_____Automatic coffee dispenser (20F-7)
_____Utility cart (20F-8)
_____Catheter package (20F-9)
_____Bed chair converter (20F-10)
_____Surgical pump (20F-11)

PRODUCT LITERATURE

_____Liquid oxygen (20FL-1)
_____Hospital equipment (20FL-2)
_____Fund-raising guide book (20FL-3)
_____Laboratory fume hoods (20FL-4)
_____Liquid detergent (20FL-5)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

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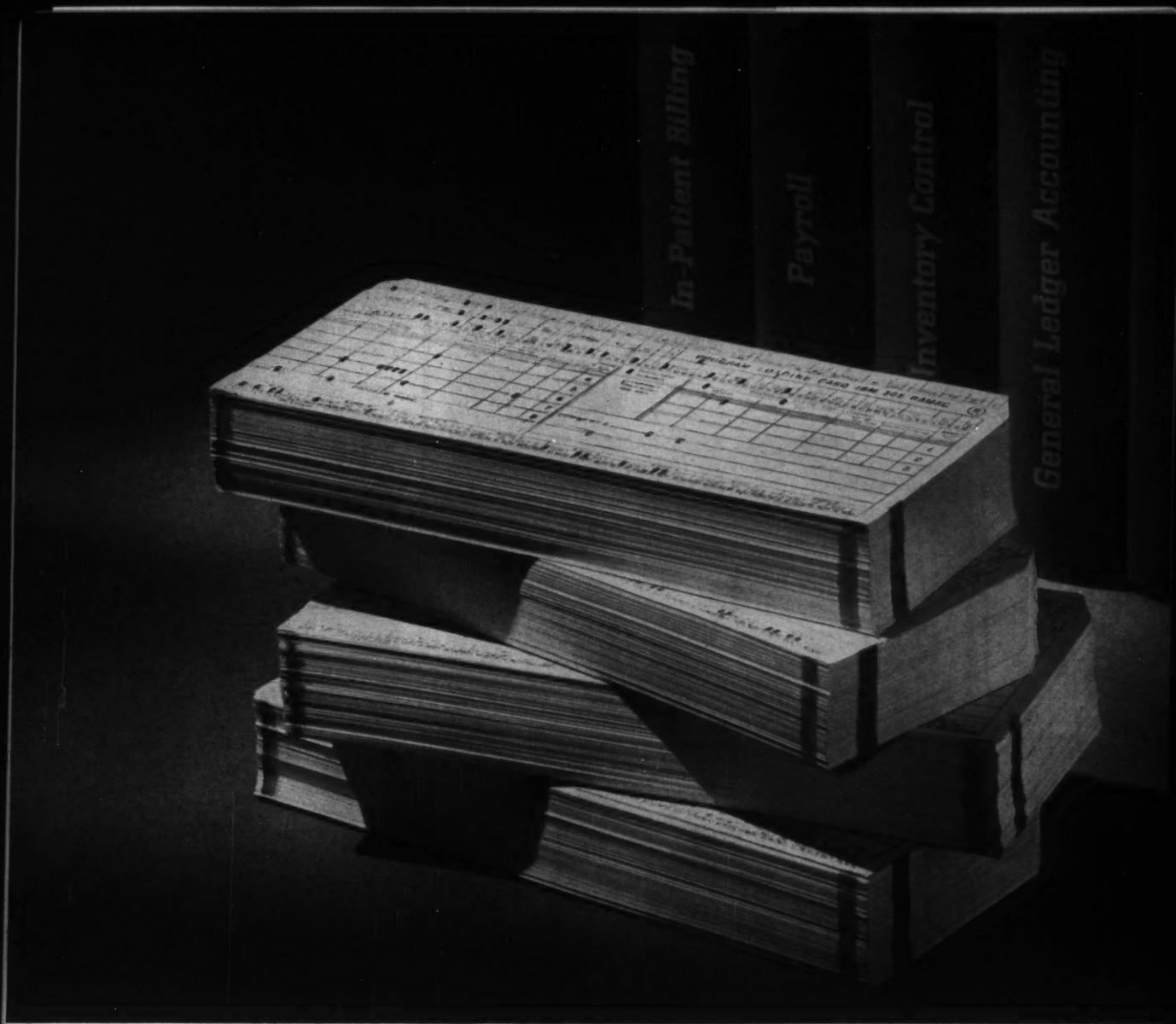

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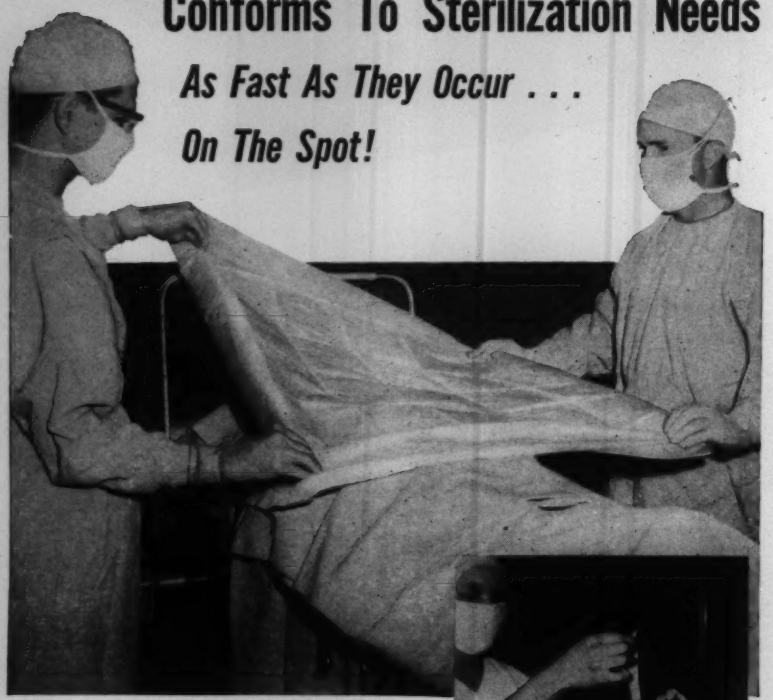

Simple sheet of sterile Patapar is used as a drape to keep perspiration and contaminants from migrating.

• Patapar Vegetable Parchment + sterile scissors + the ingenuity required to cut out a paper doll can remove all the limitations imposed by the use of cloth in sterilization. This absolutely pure (FDA Accepted), Vegetable Parchment can be cut and shaped to cover or isolate incision and wound areas *during an operation.* It can be tailored precisely, ahead of time, to meet specific needs. And, of course, Patapar is becoming increasingly popular as ready made boots, bags and other items.

Patapar possesses amazing wet strength. It will transmit steam or sterilizing gas. It can be creped to make it limp . . . or it can be used in its smooth, crisp state. It is tough, lint-free and it presents an impenetrable barrier to contaminants. Patapar can be used more than once—butit's *economical enough for one-time use.*

Send for free samples of Patapar 27-2T. When you receive them, subject them to steam, heat, weight, pulling, tearing, or what have you —and your imagination will tell you the rest!

A ready-made sterile Patapar catheter bag makes it easy to prevent non-sterile contact.

Ready-made Patapar disposable operating room boots. They are grounded by simply moistening bottoms.

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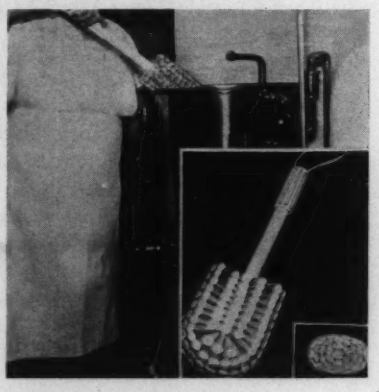
opened to 2 by 8 in. or 2 by 16 in. without exposing raw edges. It can also be adapted to the stick sponge procedure. *Johnson & Johnson, Dept. H20, New Brunswick, N.J.*

Head halter (20F-5)

Manufacturer's description: The cross strap harnessing gives firm support to the head, whether in the flexed or extended position, and one size fits all patients. The occipital straps relieve pressure on the chin and may also be adjusted for tarticallis. There is no seam at the chin, and the zigzag stitching prevents binding and curling after the halter has been washed. *Zimmer Mfg. Co., Dept. H20, Warsaw, Ind.*

Oval brush (20F-6)

Manufacturer's description: This food-service brush has an oval head design and features white, nylon bristles firmly anchored in forward angled tufts. The brush aids in cleaning coffee urns, ice cream cylinders, stock pots, steam kettles



and other utensils and equipment. *Sparta Brush Co., Dept. H20, Sparta, Wis.*

Automatic coffee dispenser (20F-7)
Manufacturer's description: Containing only two moving parts, the dis-

penser has no float or timer, requires no prebrewing, produces no waste and does not require cleaning. Water is heated in the dispenser, and by means of a push button, the proper amounts of coffee and hot water are metered automatically into a cup, pot or glass serving container. *The Nestle Co., Inc., Dept. H20, 100 Bloomingdale Rd., White Plains, N.Y.*

Utility cart (20F-8)
Manufacturer's description: Featuring double-tubular corner post con-

struction, this stainless steel cart has 14-gauge steel inner posts and chrome-plated outer post sleeves that may be removed to permit alternate spacing of shelves. Ball bearing swivel casters provide ease of handling, and both the shelves

for your Intensive Care Department

HILL-ROM offers two new units:
one for adults—one for pediatrics

Al left: No. 48-10 Adult Bed. Extra equipment includes I.V. Rod, chart holder, drainage bottle and oxygen tank holders.

At right: All mechanism enclosed in center channel. Spring and mattress fold into compact, easily-cleaned unit.

Both of these beds are light and safe for easy moving. Aluminum sides and ends. The anodized aluminum side guards can be raised or lowered with one hand. To lower, simply release the side positioning bracket. All required spring positions available. National Fabric bottom is rustproof, durable, easily cleaned. Moulded bumper around entire frame of both beds provides complete protection to walls and doorways.

The adult bed has 10″ conductive rubber tired casters—pediatric bed has 6″ casters, all with swivel locks and brakes. Adult bed has 6 I.V. rod receptacles, pediatric bed 2. Sleeping surface of adult bed 30″ x 78″, pediatric bed 30″ x 54″. Overall dimensions pediatric bed 35¼″ x 62¾″.

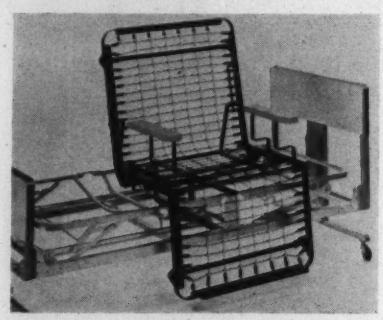
HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

and casters are removable and interchangeable. *Everest & Jennings, Inc., Dept. H20, 1803 Pontius Ave., Los Angeles 25.*

Catheter package (20F-9)
Manufacturer's description: This sterile package for catheters provides for instrument-free opening with an accepted aseptic technique and is securely sealed to maintain sterility of the catheter. Two exterior tabs peel apart and away from the sterile interior, and the presterilized package also saves time

by eliminating processing and autoclaving. *C. R. Bard Co., Dept. H20, Summit, N.J.*

Bed-chair converter (20F-10)
Manufacturer's description: A patient can now be placed in a sitting position on either edge of a hospital bed by means of this converter which includes springs, mattress and linens and swings out to form a chair at right angles to the bed. Standard equipment includes removable arm rests and 4-in. foam mattress. *The*



Bed Converter Corp., Dept. H20, 25 California St., San Francisco.

Surgical pumps (20F-11)
Manufacturer's description: Completely compact stainless and aluminum cabinets house the power and pump units in this heavy-duty surgical pump. The model features a

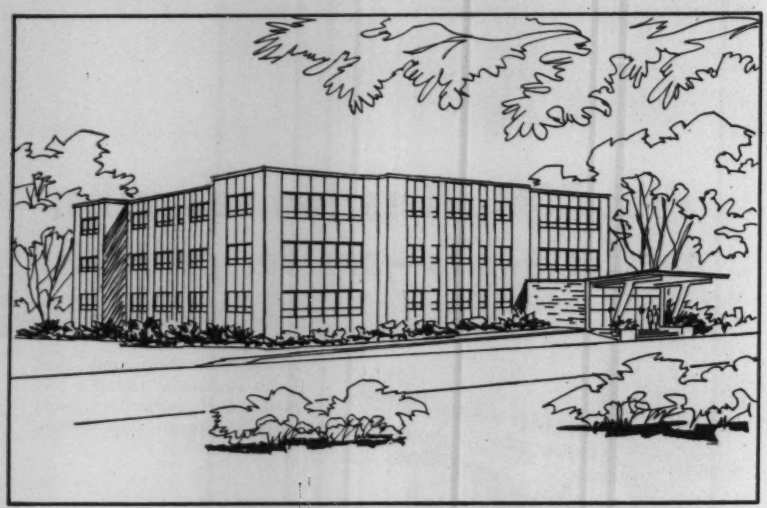
patented self-oiling system which maintains pumps and requires refilling only three or four times a year. *V. Mueller & Co., Dept. H20, 320 S. Honore St., Chicago 12.*

product literature

SEE COUPON, PAGE 84

Liquid oxygen (20FL-1)—A portable, liquid oxygen cylinder, for oxygen therapy use in both hospitals and homes, is described in this

FUND-RAISING SUCCESS



New addition to Mercy Hospital, Woonsocket, R. I.

Woonsocket Mercy Hospital Tops Goal by 18% with Ketchum, Inc. Direction

Enthusiasm was high and the need was evident. All Mercy Hospital lacked to build a new wing was the money. The Campaign Committee under Chairman Joseph O'Donnell, called in Ketchum, Inc. for professional fund-raising counsel. $300,000 was the goal.

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four-page booklet. The cylinder has a capacity of 3000 cu. ft. of oxygen, which reduces the need to change cylinders frequently. One cylinder should supply the average patient for five days. *Linde Co., Div. of Union Carbide Corp., Dept. H20, 270 Park Ave., New York 17.*

Hospital equipment (20FL-2)—A catalogue for hospital administrators, dieticians and nursing home managers. This 94-page booklet, printed in two colors, features food service equipment, supplies and kitchen equipment for use in hospitals, sanitariums and nursing homes. *Edward Don & Co., Dept. H20, 2201 S. LaSalle St., Chicago 8.*

Fund-raising guide book (20FL-3)—This guide book illustrates how to organize a successful fund-raising campaign and describes the three main divisions of the campaign: preparatory; operations, and projective. The book also explains in detail the steps necessary to make each division of the fund-raising campaign successful. *American City Bureau, Dept. H20, 3520 Prudential Plaza, Chicago 1.*

Laboratory fume hoods (20FL-4)—Material covered in this 16-page booklet consists of reasons for the use of fume hoods in a laboratory, a glossary of terms commonly used in discussions on fume hoods, illustrations of different types of fume hoods, a comprehensive description of methods to test fume hoods and fume hood operating and safety precautions. *Kewaunee Mfg. Co., Dept. H20, 5082 S. Center St., Adrian, Mich.*

Liquid detergent (20FL-5)—Described in this bulletin is a cleaning agent recommended for use in a concentration of 1½ oz. per gal. of water. The detergent will clean, sanitize and deodorize, and may be used with the ordinary cleaning techniques of sponge, mop, floor machine, spray or flood. The cleaner is odorless, nonstaining, readily soluble in both hard and soft water and is available in 5- and 55-gal. drums. *Armour & Co., Grocery Products Div., Dept. H20, 1355 W. 31st St., Chicago 9.*

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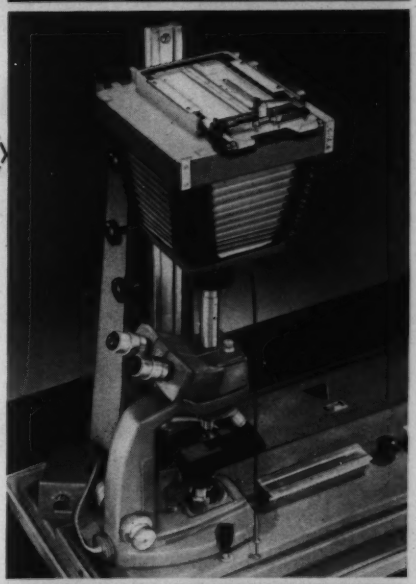

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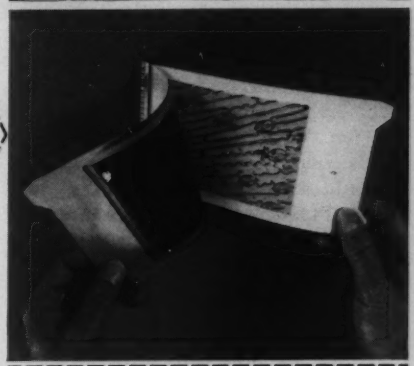

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Management tools for the executive housekeeper

by ALICE WAYLAND

Work schedules, written procedures, job descriptions and detailed budgets are all management tools in the hands of the executive housekeeper which permit her to manage her department more efficiently, according to the author, who describes how these contribute to the total operation of the department.

HOUSEKEEPING HAS almost become a science, and when it is properly applied it provides the sanitation that hospitals are expected to have, but which they all too frequently in past years have lacked. The hospital housekeeper must be prepared by training or experience to apply housekeeping methods and techniques effectively. She should be familiar with the principles and functions of supervision. Work schedules and check lists should be routine for her. She should develop written procedures for all tasks and training programs should be established because unskilled persons are frequently the only available workers.

The housekeeper must be alert to new methods, supplies and equipment that will ensure continued efficient operation. She must be able to lead her employees and to motivate them to maintain good sanitation practices. She must coordinate the department's efforts with those of other departments. The housekeeper must also maintain adequate records, prepare efficient work schedules and submit a proper budget to administration. Furthermore, she should inculcate into her personnel a sense of their prime responsibility to serve the needs of patients.

Alice Wayland is executive housekeeper, Mount Carmel Hospital, Columbus, Ohio.

This paper is based on a presentation at the 46th annual convention of the Ohio Hospital Association.

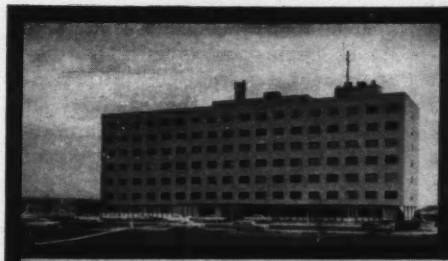
HOUSEKEEPING RECORDS

The housekeeping department must maintain records of personnel, work and supplies because a busy housekeeper cannot keep in mind all details of the department. By keeping records on her personnel and work, the housekepeer is ready at any time to analyze her department's operation. A record file for each employee, should include application blanks, references, comments on his interviews, health record, accident record, time record and evaluation reports.

To assist in controlling her department, the housekeeper should maintain records pertaining to (1) the floor plan of hospital; (2) organization charts of the hospital; (3) work schedules; (4) supplies; (5) repairs, and (6) inventories of supplies, equipment, furniture, etc.

The executive housekeeper occupies a prominent position as a hospital department head, and her value to the hospital is dependent to a large degree on the success with which she uses modern record-keeping techniques in her daily routines. Although some executives have managed successful departments over the years by instinct alone, it is suggested that many more need the assistance of complete and adequate records.

Some records are needed to: (1) evaluate performance properly; (2) plan work effectively, and (3) make frequent reports to administration. Accurate historical records of day to day operations make such performance possible. Records eliminate the personal element in reports, thus giving meaning and authority to expressed opinions. When departmental expenses and costs must be defended to management, records make it possible to do this factually. If the administration requests curtailment in departmental expenses, the housekeeper may find in her records the



Lutheran General Hospital,
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Architects:
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Consulting Engineers:
E. R. Gritsch & Associates.

General Contractors:
William E. Sweitzer & Co.

Heating Contractor:
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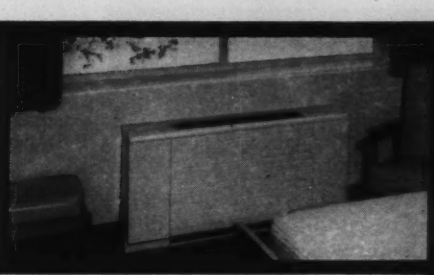

Crane Fan-Coil units fit the temperature to the patient all year 'round in this 316 bed hospital

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means by which such economies can be effected.

Most important of all, to some housekeepers, is the comfort of being able to justify her opinions and decisions through good departmental records. Administrative decisions based on poor judgment but adequate records occasionally can be excused, but action based on poor judgment and inadequate records can have serious implications.

Too many hospital housekeeping departments are operated in a state of constant emergency, which causes confusion, waste and general inefficiency. Although it is impossible to eliminate these emergencies entirely because of the nature of hospital work, their effect can be lessened considerably by systematic planning. It is extremely doubtful whether such planning can be done without using work data which has been properly recorded and filed.

FORECASTING REQUIREMENTS

Forecasting also is an important part of the executive housekeeper's responsibility. Administrators frequently want to know how many maids and porters will be needed during a future period of time. The cost of floor and wall maintenance always is watched carefully, and questions on the value of outside contracts are routine. On these and other details, the housekeeper is expected to give informed opinions based on recorded experience. Offhand opinions are acceptable for an informal conference, but a written statement taken from accurate records is wanted by top management when decisions involving sizable expenditures are made. Since any plan for the future cannot be made nor defended without accurate knowledge of past happenings, accurate historical records appear to be the main means by which this important responsibility of management can be discharged satisfactorily.

WORK ASSIGNMENT RECORDS

Since approximately 85 per cent of the housekeeping department budget is devoted to personnel expense, the construction of a system to record and accumulate work assignment data is of primary importance. Payroll records routinely produced in the business office are not suitable because the housekeeper wants to know more than the total wages paid and hours worked. A record of the work accomplished in the department is essential, and this must be developed through the use of supplementary departmental records designed specifically for this purpose.

WORK RECORDS DATA

A labor record and a daily assignment record which answer the following questions can supply this data in a way most helpful to the department head:

1. In what area of the hospital was the work done?
2. What specific section of the hospital was being given attention?
3. What type of work was assigned?
4. To whom was the work assigned?
5. When was the work done?
6. How long did it take to complete the assignment?

If the above questions can be answered for any specific assignment, an analysis of such information, when it is recorded over a considerable period of time, produces material of great value—providing the records are maintained to make analysis a practical operation.

The housekeeper should know what she spends because the cost of supplies can amount to 10 per cent of the entire cost of running the department. The housekeeper cannot be "on top of her job" if 10 per cent of her total costs are not known. Without this knowledge, she cannot compare last year's costs to this year's, or determine whether supply costs are out of line. These figures are essential for projecting budget figures. When she is armed with cost figures on every phase of the housekeeping operation, the executive housekeeper can make a positive contribution to administration planning.

Specific procedures must be established as a foundation for the daily operation of the department. No one can work on a basis of guesswork and supposition. The most important thing the housekeeper needs to know when preparing schedule outlines is how the work begins and ends in her department. Learning to control personnel through the medium of schedules is of sufficient importance to warrant many weeks of study and practice.

Every employee in the housekeeping department should have an understanding and detailed description of the job he is to do and when it is to be done. These descriptions, when formalized and placed on paper, assist everyone who uses them. Work schedules and definitions of duties effectively negate the temptation to quickly hail the nearest maid or porter with a request for services without regard to his department duties and assignments. Hospital personnel on all levels must accept the fact that the time of all employees is budgeted and understand that only the department head concerned has the authority to interrupt the schedule.

A DIFFICULT CHALLENGE

The housekeeper's most difficult challenge comes from the nursing service. Historically, in hospitals there has been friction between nursing supervisors and executive housekeepers. Much of this is not the fault of either because assignments and duties have overlapped. This unfortunate situation leads to serious misunderstanding and low morale among nurses and housekeeping employees. Consequently, in the final analysis, the patient suffers.

Nursing supervisors have the responsibility of assisting the housekeeper in seeing that the work is done properly without undue disturbance to the patients and the nursing service. It takes a great deal of effort on the part of the executive housekeeper to see that the cleaning services are performed efficiently, and yet are coordinated with the work of attending physicians, the house staff and nurses. As a by-product of scheduling, a good basic understanding of production standards, work flow and distribution of work load can be acquired.

PREPARING THE BUDGET

Budgeting is simply a forecast of the activities that the housekeeper

envisions for the entire department for the next year. This requires taking into consideration fiscal planning, accounting and control. A budget is an estimate of the amount of money that should be spent for various purposes in a given time. The housekeeper should decide what she would like to buy to increase her department's efficiency. She should make a list indicating whether the items are replacements or additional equipment, and she should show the costs in round figures. She should estimate the annual consumption of cleaning supplies and include this item in the proposed budget.

BUDGET COMPONENTS

A budget, which is necessary to operate any division of the hospital, usually consists of three major parts: salaries, supplies, and expenditures for new equipment, etc. An administrative housekeeper must learn to correlate the budget and operating costs if she hopes to sell top management on her proposed expenditures. The housekeeper's attitude toward budget preparation should be one of keen interest, for a budget can be fascinating in stimulating and developing ideas that will help to produce a well planned cost reduction program. The budget requires a detailed breakdown of expenditures, but the extent of the breakdown should be determined by the business practices of the hospital.

The budget should list actual expenditures for the previous year and estimated expenditures for the coming year. If a decided increase is requested in the proposed budget, a remark sheet explaining the need for the increase should be attached; otherwise, the budget may be returned by the accounting department with a request for explanation.

Budgets certainly require decisions by the housekeeper; decisions which she cannot avoid making, for the current of progress leaves no place for indecisiveness. Therefore, during the year, she should gather new and constructive ideas and put them to work in preparing the budget. New products and equipment will influence, to some degree, budget decisions, as well as new ideas, so the housekeeper should learn about these, too.

In the past few years, a whole new world of synthetics, plastics, fabrics and electronic devices have made earlier methods of and approaches to the profession as obsolete as many of the gadgets of grandmother's day. The space age, with its vast research and development resulting in remarkable technological advances, has produced many kinds of labor-saving devices and is already producing or promising more almost unbelieveable ways of making work easier and less expensive in housekeeping departments.

Researchers are looking for ways to make formerly unstable, nonwoven substances strong enough for use in insulating materials, polishing cloths, towels and disposable garments. Research is being done in the textile field to find ways to protect fabrics more and make them work for us. It is claimed that fibrous glass, plastic or metal backings will do much toward control of heat, light and glare, and also fabrics treated in this manner will shed dirt and greases.

One manufacturer of heating and air-conditioning units has developed an air cleaner—an electrostatic precipitator—which strips the air of dust and dirt particles. Another is testing electrically activated windows which will close automatically when a cold wind blows, rain starts, or the room temperature falls below a certain predetermined point.

PLASTIC PLUMBING

A research organization is testing a new wall surface made by laminating plastic to the wall itself —it will withstand children's rough treatment. The plastic makers are working on pipes for indoor plumbing, which they claim will reduce cost because no joints will be necessary to round corners —this pipe will just bend around them.

A manufacturer of floor finishes predicts that in the not-too-distant future, new chemical advances in the development of synthetic ingredients will make possible self-polishing floor waxes that will be impervious to spotting by water or even soap, but which will be readi-

(Continued on page 125)

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(Continued from page 81)

accepted accounting principles, procedures, reports and analysis guides in easy to read, nontechnical terms. In its brief but adequate composition, the manual presents specific guides to assist administrators in acquiring an understanding of, and an ability to utilize, accounting and statistical data to effect more efficient planning and control of the financial management activities of their institutions.

There are 23 comprehensive illustrations, a simple but adequate index or table of contents and 33 documented references, which when added to the context represent an unprecedented reference guide to assist in making administrative decisions and solving financial problems.—RAY S. MATYLEWICZ, *staff consultant, American Hospital Association.*

Obstetrical nursing techniques

ASEPTIC NURSING TECHNIQUES; A SURVEY OF MATERNITY DEPARTMENTS IN THIRTEEN MEDICAL CENTERS. Margaret W. Thomas. Washington, D.C., Government Printing Office, 1960. 145 pp. $1 (U.S. Public Health Service Publication No. 788)

The author has skillfully woven together this survey report of nursing practices in 13 large medical centers as they relate to the prevention and control of infection in the obstetrics-newborn units and formula preparation areas.

Two criteria in selecting the medical centers were that: (1) the hospitals have an infections committee and (2) the hospitals have on their staff one person who had been associated with the U.S. Public Health Service Communicable Disease Center.

The sampling of these hospitals seems adequate because one would expect the most enlightened techniques to prevail in medical teaching centers.

Source documents containing principles for development of practice standards are expertly compiled on the work sheets used for conducting this survey and they can be effectively utilized as evaluating guides in any hospital concerned with infections control.

A quick reference chart for recommended practice related to infections control as set forth by standard documents is very good, but one must keep in mind, as the author states, that there were inconsistencies between certain standard documents and in many instances, there were no written recommendations set forth by a nationally recognized authoritative body.

Logic and readability characterizes the presentation on physical facilities, observation of technique methods and the consequent specific recommendations for prevention and control of infections. This is done in a manner which highlights the contrast with physiological and psychological patient care patterns.

Results of the survey show that there are inconsistencies in practice not only among hospitals, but also in services in the same hospital. Many practices are inconsistent with known standards and scientific facts. Frequent references were made to areas needing further investigation. The lack of proven microbiological bases for many procedures carried out by nurses and the need for re-evaluating the traditional aseptic techniques were emphasized. Need for further studies are listed in the report. The bibliography and appendixes are excellent.

This publication should be a valuable guide and reference to hospital administrators and medical nursing groups who are working together to bring under control the problem of antibiotic-resistant staphylococcal infections.—EDNA JANSSEN REED, *supervisor, obstetrical-nursing service, Vanderbilt University Hospital.*

Maintenance techniques

TECHNIQUES OF PLANT MAINTENANCE AND ENGINEERING, Volume XI. Clapp & Poliak, Inc., New York 17, N.Y., 1960. 341 pp. $10.

This book is a record of the proceedings of the technical sessions held concurrently with the 1960 National Plant Maintenance and Engineering Conference held in Philadelphia, January 1960. Included in its 341 pages are copies of formal presentations on 25 subjects, together with a record of the

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question and answer sessions that immediately followed each presentation, and a record of 10 round-table discussions, each on a specific industry. The question and answer sections provide answers to many questions that often confront hospital engineers. There are also a number of sample forms, graphs and diagrams.

Some of the most interesting topics covered, from the standpoint of hospital maintenance, are:

1. Supervisory training
2. Maintaining control instruments
3. How to use industrial engineering techniques in maintenance
4. Maintenance problems of small plants
5. The place of the maintenance function in purchasing
6. Getting at true maintenance costs for purposes of comparison
7. How to plan and schedule maintenance work for effective control
8. Lubrication of bearings
9. What the plant engineer should know about building
10. The practical use of incentives in maintenance
11. Plant engineering in planning to combat disaster by tornadoes
12. Preventive maintenance at work

Although most of the procedures outlined are for use in industrial situations, the material should be of special value to hospital engineers as a reference book on maintenance work.—GERALD A. WEIDEMIER, *staff representative, American Hospital Association.*

On improving nursing homes

NURSING HOME STANDARDS GUIDE. (PHS Publication No. 827) U.S. Public Health Service. Washington, Government Printing Office, 1961. 63 pp. 45 cents.

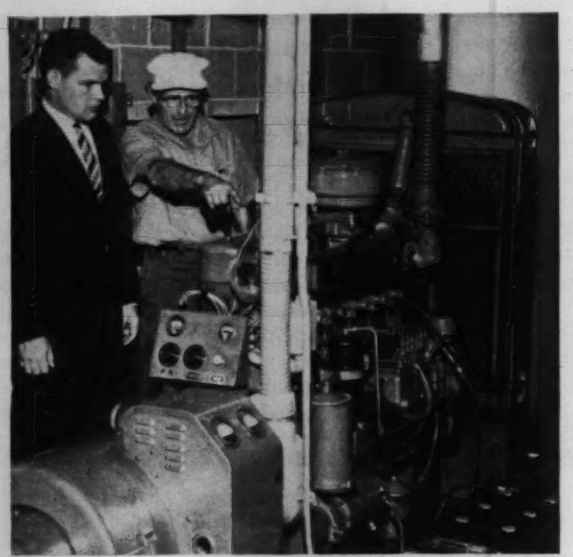
This report represents the combined thinking of a number of organizations, including the U.S. Public Health Service, with respect to improving and strengthening nursing home licensure laws.

It is anticipated that the report will be effective in raising standards of patient care through recommendations covering every phase of nursing home construction, administration, nursing service and safety.

The report opens with a rather universally accepted definition of a nursing home providing skilled nursing care and from there, through seven chapters and 59 pages, reviews each area of responsibility of operation in detail.

This report can provide valuable information to nursing home licensure agencies at all levels as well as health and allied organizations whose primary interest is in improving the care of the aged and chronically ill.

The report is basically the result of recommendations coming out of the 1961 White House Conference on Aging strengthened by a similar recommendation by the Senate Subcommittee on Problems of the Aged and Aging, Committee on Labor and Public Welfare.—FRANK C. BATEMAN, staff representative, *Council on Professional Practice, American Hospital Association.*



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Engineer Leo V. Brown explains to administrator L. H. Furlong (left), how the Allis-Chalmers diesel electric set cuts in and takes over any load at Community Hospital, La Porte, Ind.

"The operating room went dark...

then instantly the lights flashed on again using the Allis-Chalmers auxiliary unit"

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"We are indeed grateful for having an Allis-Chalmers standby engine-generator set in time of need," said L. H. Furlong, Administrator of the Community Hospital, La Porte, Indiana.

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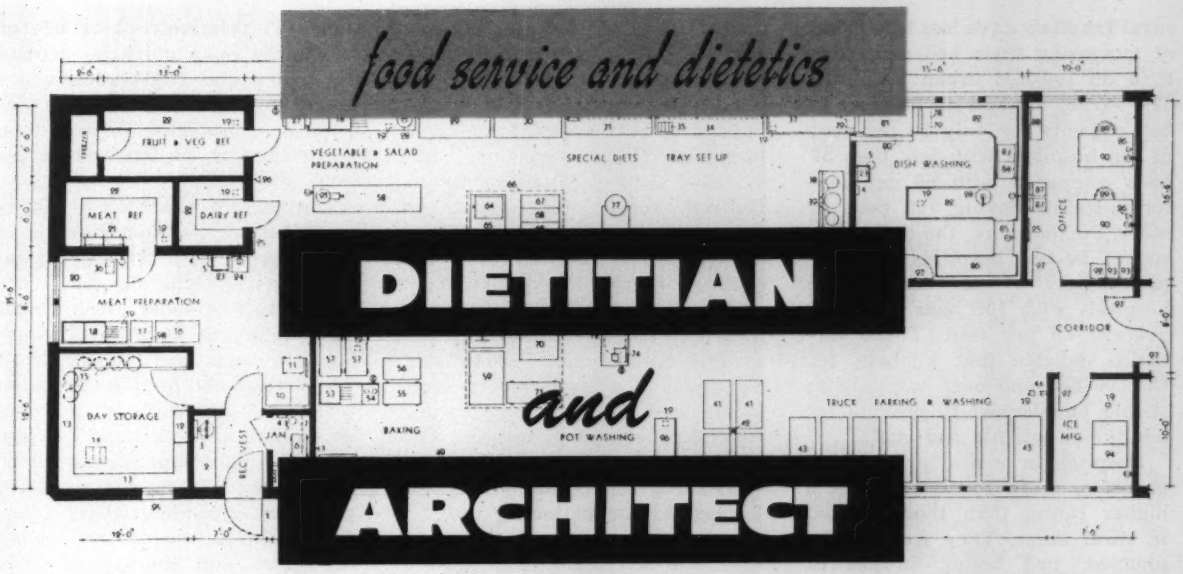


work together in kitchen planning

by WILBUR R. TAYLOR

Analyzing the tasks to be performed is the first step toward planning an efficient hospital kitchen, according to the author. He states that the dietitian can help the architect by making such an analysis and also by evaluating how well the preliminary designs for the kitchen carry out the stated functions of the department.

THE BASIC PRINCIPLES of planning hospital kitchens are simple. If the requirements are studied and clearly visualized at the beginning of a project, much time and money will be saved. Better planned departments—and hospitals—will result.

Planning a hospital kitchen or any other hospital department involves four steps: (1) Define the tasks. (2) Select the equipment. (3) Arrange the equipment for a smooth functional workflow. (4) Construct an envelope around this workflow.

Planning for the dietary department is only one aspect of planning for the hospital as a whole. In the case of a new project, when a hospital staff has not yet been assembled, the first two steps are the responsibility of the administrator, with the help of a dietary consultant, if available. In planning additions or in remodeling existing institutions, when a staff dietitian is available, she can aid the architect in the first two steps—defining the tasks and selecting the equipment. These preplanning steps will be discussed later under the subject of "program stage". The hospital administrator usually acts as coordinator of the planning for the various departments and helps integrate the programs for each department into the plans for the hospital as a whole.

The third step in planning—arranging the workflow—is the responsibility of the architect, with consultation and review by the dietitian. The fourth step—constructing an envelope around the functions—is solely the responsibility of the architect after an understanding has been reached concerning the first three steps.

Wilbur R. Taylor is chief, Architectural Section, Architectural and Engineering Branch, Division of Hospital and Medical Facilities, Bureau of State Services, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C.

This article is adapted from a presentation at an American Hospital Association Institute for Shared Dietitians and Dietary Consultants held in May 1961.

CAUSES OF DEFICIENCIES

Since kitchen planning appears to be so simple, why, then, are such facilities so often deficient? Such deficiencies result from poor preplanning. The importance, or rather the necessity of preplanning, cannot be overemphasized. An important factor to consider is the possibility of future expansion of the hospital. Another factor is that insufficient space may be provided to permit a change in the originally planned food system, if this becomes necessary. Although the cooking area generally remains relatively fixed, the serving area of the kitchen is subject to change. If space requirements are inadequately determined, certain work will be carried out in cramped areas, and inefficient service will result.

Size and location of hospitals have an important effect on the assessment of their future prospects at the planning stage. Recent studies of 146 Hill-Burton hospitals have shown that 50-bed

rural hospitals have less likelihood of increasing their bed capacities than do 100-bed urban hospitals. The survey showed an increase in bed capacity for only 20 per cent of the hospitals with less than 50 beds compared with 60 per cent for hospitals having 100 beds or more. Furthermore, the daily census of 50-bed hospitals was approximately 57 per cent, while hospitals with 100 beds and over average 85 per cent. These statistics indicate that kitchens for the 100-bed-and-over hospital size should be planned to provide for additional patients and staff.

Hospitals in or near urban areas generally were found to merit a higher rating than those located in rural areas. They were better planned, had better finishes of building materials and equipment and apparently were more efficiently staffed. The ratio of the dietary department staff to patients was approximately 1 to 10, while the smaller hospitals in rural areas had a staff ratio as high as 1 to 7.

The centralized type of food service was usual, although the bulk system was used in some hospitals. There were also split systems, such as bulk or "decentralized" service for patients on regular diets, and a "centralized" system in which trays are assembled in the dietary department for those on modified diets. Various methods of transporting trays to the nursing unit were used. These included dumb-waiters, horizontal and vertical conveyors and several types of mobile units. Often in very small hospitals, trays were carried individually from the kitchen to the patients.

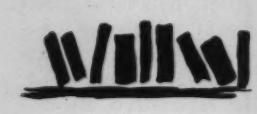
KITCHEN DEFICIENCIES

Some of the deficiencies in the kitchens surveyed were the following: (1) inadequate freezer storage; (2) too small day-storage space; (3) insufficient space for setting up trays; (4) poor ventilation; (5) relatively short life of galvanized sinks and tops—around five years, and (6) corrosive action of untreated water. (This was a serious problem. Dishwashers, water heaters, piping and valves were affected.)

The general condition of kitchens, however, was considered good as compared with other hospital departments. Generally, the location, size, functional arrangement and equipment were satisfactory. Most kitchens had plaster walls and ceilings and quarry tile floors; a few had tile walls or wainscot and acoustical tile ceilings. Usually, floor drains were provided and were satisfactory. Occasionally, poor choices of material were evident, such as the use of asphalt tile floors and linoleum counter tops in unsuitable areas, as well as of galvanized sinks, most of which required replacement.

What can be done to improve hospital kitchen planning? The answer lies in several correlated

DIETARY REFERENCE SHELF



Diet and Menu Guide, 1961. This guide is designed to provide understanding of good institutional food service, particularly for small hospitals, nursing homes and other institutions. Sample menus are included **$2.50**

Food Purchasing Guide, 1953. A guide for buying food that includes descriptions of the unit of purchase, weight, size of serving portion, the number of servings to be expected from purchase units, portion costs, and quantity buying **$3.00**

Hospital Food Service Manual, 1954. Comprehensive food service guide adaptable to hospitals of all sizes. Includes details of menu planning, preparation of food orders, purchasing, storage and service, care of equipment, sanitation, personnel and accounting . . . **$6.00**

Readings in Hospital Dietary Administration, 1952. A collection of articles from 1935 to 1951 on hospital dietary service, covering such subjects as organization, planning and equipment, kitchens, personnel, food service and diets, purchasing, sanitation and accounting **$5.00**

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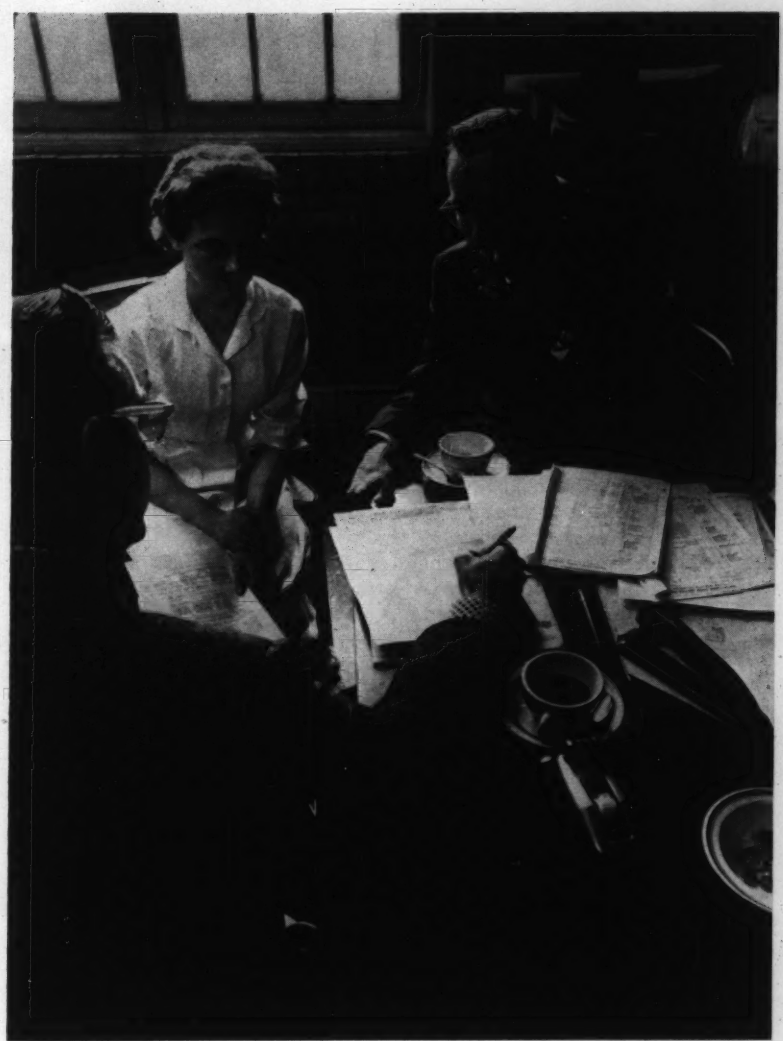

AN UNDERSTANDING REACHED between the architect, the hospital administrator and the dietitian about the functions and physical needs of the dietary department is a necessary step before the architect can properly plan the hospital kitchen.

factors, including the following:

1. The need for the architect to have a better understanding of the hospital's dietary service requirements.

2. A detailed written presentation of these requirements by the dietitian and her review of the architect's plans at the schematic and preliminary stages.

3. The approach to each problem according to the specific requirements of each hospital.

THE PROGRAM STAGE

Perhaps an explanation of how the architect begins his planning for the hospital as a whole will help to show how plans for the dietary department fit into the over-all design. This initial step is usually referred to as the "program stage". Functional planning should always precede architectural planning.

Before the architect starts to plan, an understanding should be reached concerning the requirements of the hospital, its services and its relationship to community needs. The number of beds required and the types of services to be offered will be affected by other facilities in the community. After these determinations have been made, a written program should be developed. The program, as it relates to architectural planning and construction, is the written description of all requirements to be incorporated in the design of a project. This program should show, with reasonable completeness, the requirements of each department of the hospital: approximate area, major equipment and personnel. This preliminary program should be further discussed by the hospital administrator, department heads, architect and consultants. From these discussions, a definitive program should evolve which clearly states the requirements and services of the hospital.

The architect will need all information that affects:

1. Physical size of the department.

2. Functional layout of equipment and space.

3. Equipment that will affect the mechanical and utility services to be provided.

4. Finishes and materials to be used.

In the part of this program relating to the dietary department, a detailed outline should be furnished of all requirements for this department, such as the following:

Meal service.

1. Number of meals to be served per day to patients and employees (breakfast, lunch and dinner).

2. How and where patients and staff are to be served. Will a completely centralized tray system be used for patients, or will a bulk system be provided and trays assembled on each floor? Will a cafeteria or table service be provided for staff and employees?

3. How will meal service periods affect the size and capacity of equipment, as determined by peak number of patients, staff and employees to be served at any one meal, and replenishment of cafeteria?

Other determinations:

1. Staples to be kept in the main storeroom and the frequency with which deliveries are to be made to kitchen storage.

2. The extent to which baking will be done.

3. The frequency of deliveries

for meats and perishables; indicate if they are to be made every three days or every five days.

4. Whether fabricated or large cuts of meats are to be purchased.

5. Where ice will be made; indicate whether a small unit is to be provided for the kitchen.

6. How dishwashing will be handled; indicate if it is to be centralized except for contagious wards or tuberculosis wards; also indicate how trays from isolated patients are to be handled.

7. Where the formula room will be located. It should not be part of the kitchen.

8. Whether floor pantries will be provided. If so, how will they be used?

9. The number of toilet and locker facilities.

The next part of a written program should consider each physical element of the kitchen, including location, special facilities, types of equipment and activities. Examples of what should be included are:

1. Receiving vestibule: Location at or near end of kitchen and convenient to refrigerators; allocation of space for equipment, such as a platform scale and a counter with a counter scale.

2. Refrigeration and freezer capacity: For meats, vegetables, fruits, dairy products, frozen foods.

3. Preparation equipment for meats.

4. Preparation area for vegetables and salads.

5. Day storage: Indicate amount of shelving needed.

6. Janitor's closet: Indicate equipment and desired location.

7. Baking equipment: An example is a combination baking and roasting oven for a small hospital.

8. Cooking equipment: Indicate approximate capacity or size of each item, with allowance for possible future increased service.

9. Serving and tray set-up area: Describe the system and equipment, as well as its functional location in relation to other areas.

10. Dishwashing room: Location, size and capacity of machine.

11. Potwashing area: Location and equipment.

12. Washing trucks (if used) or other type of equipment.

13. Food waste disposal: Grinder, storage, or other method.

14. Office requirements: Number of personnel, space and location.

15. Employees' facilities: Handwashing facilities required in food-handling areas; drinking fountains; lockers required.

16. Cafeteria: List equipment, number of tables, number of seats to be provided.

After the written program for the hospital has been completed and the hospital board and the architect have selected the site for the building, the next step is the development of small-scale schematic drawings by the architect. From the information in the written program, the architect will show the building area required, the relation of the various units to each other and the traffic flow pattern. These schematic drawings should present a fairly accurate concept of the hospital design. These plans should be thoroughly studied by all concerned, and any changes should be indicated at this time.

Following approval of the schematic drawings, the architect can estimate the project cost. This estimate should include the cost of construction of the building, fixed and movable equipment, all fees, inspection and supervision, grading, walks, roads, landscaping and contingencies.

PRELIMINARY DRAWING STAGE

After the cost estimates have been approved, the architect will develop the plan at a larger scale, showing major items of equipment. This is known as the preliminary drawing stage. At this point, the architect and his structural, mechanical and electrical engineers will study the requirements to determine the most economical and practical system for foundations, structural framing, plumbing, heating, electrical wiring, ventilating and air conditioning. Other decisions must also be made, such as the most economical type of fuel to use and the most suitable materials for operation and maintenance.

As a result of this more detailed study, some changes may be required in the program. The architect can now estimate more accurately the costs involved and advise if any budget adjustments should be made.

During this preliminary planning phase, the architect should give those concerned ample opportunity to study the drawings and to make any necessary changes. By this time, all requirements for the hospital kitchen should be clarified and shown on larger-scale preliminary drawings, which should be thoroughly reviewed by the dietitian in consultation with the administrator.

WORKING DRAWING STAGE

After review and approval of the preliminary drawings, the architect proceeds with the last phase of his planning—the preparation of working drawings. The purpose of the working drawings is to convey to the contractor and his workmen details pertaining to the construction of the building. These drawings are made to scale and include such information as the architectural, structural, mechanical and electrical details which can be presented more clearly by drawings than by the specifications.

The specifications supplement the drawings and prescribe qualities of materials and workmanship to be furnished by the contractor. Specifications should be written in simple, accurate language and divided into sections corresponding to work performed by the various building trades and subcontractors.

Specifications for equipment may be written in two ways:

1. To indicate maximum and minimum requirements and any special features of performance.

2. To indicate specific model(s), using trade name(s) with model number(s) as standard of quality.

Although certain types of equipment may be purchased on the open market, competitive bidding is usually more advantageous to the owner. The general contractor will be responsible for the installation and performance of the equipment.

Preparation of the working

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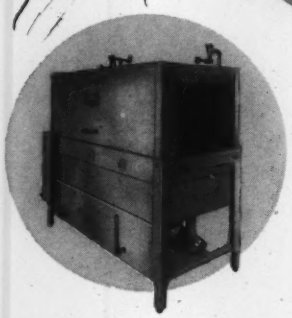

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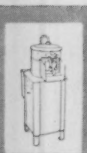

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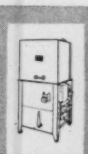

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drawings, specifications and legal documents proceeds simultaneously. The architects, engineers and specification writers work together to complete the documents. During this stage, construction and equipment costs should be checked again.

FINAL DECISIONS

The working drawings, specifications and legal forms prepared for a project represent the final decisions as to the design of the project and methods of administering the contract. These forms are prepared by the architect to provide a detailed picture and statement of all work to be done, methods to be used, equipment to be furnished and responsibilities to be assumed in order to complete a building or project. From these documents, the contractor prepares his proposal for constructing the building.

Thus, all information and requirements should be developed before the final drawing stage. It is almost always impractical to make changes during or after this stage. I would like to stress again the importance of careful evaluation during the period when the schematics and preliminary drawings are developed. At this early stage, the dietitian can be most helpful by determining the many items necessary to provide an efficient dietary department which in turn benefits the hospital service. ■

Winter Cycle Menu for the South-Southwest

SUCH southern favorites as biscuits and other hot breads, okra, black-eyed peas, grits, seasoned greens, and lima beans with ham hocks are menu items in the 21-day selective winter cycle menu designed for hospitals in the South-Southwest, with accompanying market orders for perishables. These menus are for use during December, January and February. In Texas Hash, a noon meal item in these menus, chili powder (¾ c.) is the ingredient that adds the close-to-the-border flavor to a mixture of 20 lbs. lean ground beef, 3½ qts. uncooked rice, 3 No. 10 cans tomatoes, 6 lbs. onions, 1½ lbs. green peppers, 3 lbs. fat, 1 c. salt and 1 tbsp. pepper. (Yield: 20 qts.)

The menus in this issue are the second in a four-part series of winter cycle menus published in this Journal. Winter cycle menus for the Midwest were included in the October 1 issue of this Journal. The winter menus for hospitals in the East and North-Northwest will be published in the November 1 and 16 issues, respectively.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. A moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered for breakfast.

The fall cycle menus, published in the July and August issues of this Journal, may be used during October. The Midwest and South-Southwest cycle menus were included in the July 1 and 16 issues, respectively. The August 1 and 16 issues featured fall menus for the East and North-Northwest, respectively.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served to patients on sodium or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar or substitute the water-packed variety for the diabetics.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 80 patient and personnel meals at breakfast, 120 at noon and 80 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle.

The standard is available upon request from the American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Ill.

1st WEEK SOUTH-SOUTHWEST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Frances Hoffman, administrative dietitian Women and Children's Hospital, Baylor University Medical Center, Dallas, Tex.

	morning	noon	night
monday	Orange Juice (FS) **or** Applesauce Cooked Wheat Cereal **or** Ready-to-Eat Crisp Rice Cereal Poached Egg Honey Butter Toast	Grape Juice Creamed Eggs on Rusk (FS) **or** Baked Veal Cutlet with Gravy Steamed Potatoes in Skins Seasoned Green Beans (FS) **or** Parslied Cauliflower Fruit Cocktail in Strawberry Gelatin **or** Pear Half with Cream Cheese and Pecan Stuffing Apricot Cobbler (F) **or** Royal Anne Cherries (S)	Oyster Stew Roast Beef Au Jus (FS) **or** Salmon Loaf with Cream Sauce Parslied Whole Potato (FS) Diced Carrots (FS) **or** Stewed Tomato Chef's Salad with French Dressing **or** Pea, Pickle and Cheese Salad Orange Cupcake with Orange Frosting (FS) **or** Pineapple Slice
tuesday	Ruby Red Grapefruit Half (F) **or** Apricot Nectar (S) Oatmeal **or** Ready-to-Eat Corn Cereal Scrambled Egg with Ham Bits Pecan Roll	Tomato Juice Cocktail Roast Turkey (S) with Cornbread Dressing, Giblet Gravy and Cranberry Sauce (F) **or** Braised Beef Cubes Mashed Potatoes (FS) Buttered Peas with Mushrooms (FS) **or** Baked Acorn Squash Waldorf Salad in Gelatin **or** Celery and Pickle Sticks, Radishes and Ripe Olives Hot Rolls Mincemeat Pie (F) **or** Frozen Peaches with Whipped Cream (S)	Cream of Celery Soup Cheese Souffle (FS) **or** Country Fried Steak with Gravy Buttered Diced Potatoes Buttered Spinach (FS) **or** Savory Onions Sliced Tomato and Lettuce **or** Canned Fruit Salad with Honey Dressing Vanilla Ice Cream (FS) **or** Ambrosia
wednesday	Pineapple Juice (FS) **or** Stewed Prunes Refined Wheat Cereal **or** Ready-to-Eat Bran Cereal Soft Boiled Egg	Orange Juice Italian Spaghetti with Meat Balls (F) **or** Roast Lamb with Mint Jelly (S) Potatoes in Cream Sauce (S) Lemon Buttered Broccoli (F) **or** Seasoned Green Beans (S) Green Salad with Bleu Cheese Dressing **or** Peach Half with Prune Hard Roll Lemon Sponge Pudding (FS) **or** Pear Half in Syrup	Minestrone Soup Beef Stew (F) **or** Broiled Beef Patty (S) Whipped Potatoes Buttered Asparagus (F) **or** Buttered Tiny Whole Beets (S) Cottage Cheese and Pineapple in Lime Gelatin **or** Coleslaw Ice Box Cookies (F) **or** Sliced Bananas with Cream (S)
thursday	Orange Juice (FS) **or** Grape Juice Grits **or** Puffed Wheat Cereal Scrambled Egg Broiled Link Sausage Cinnamon Toast	Cream of Corn Soup Braised Liver with Bacon (FS) **or** Porcupine Meat Balls Pittsburgh Potatoes (F) **or** Creamed Potatoes (S) Buttered Carrots (FS) **or** Celery O'Brien Chopped Tomatoes, Pepper, Onion, Cucumber and Celery in Vinegar **or** Apple, Grapefruit Salad Baked Custard (FS) **or** Peeled Whole Apricots	Consomme Roast Pork with Gravy (F) **or** Welsh Rarebit on Toast (S) Glazed Sweet Potato Seasoned Turnip Greens (F) **or** Buttered Peas (S) Apricot, Marshmallow Gelatin Salad **or** Tossed Salad with Poppyseed Dressing Cornbread Muffin Devil's Food Cake with Mocha Frosting (F) **or** Fruit Cocktail (S)
friday	Stewed Apricots (F) **or** Tomato Juice (S) Steamed Rice with Brown Sugar **or** Ready-to-Eat Wheat Flakes Poached Egg	Cream of Asparagus Soup Baked Halibut (S) with Creole Sauce (F) **or** Chicken Pot Pie Franconia Potatoes (F) **or** Baked Potato (S) Buttered Spinach (FS) **or** Fried Eggplant Dill Coleslaw **or** Peach Half with Cottage Cheese and Walnut s Lemon Sherbet (FS) **or** Green Gage Plums	Orange Juice Cheese Croquettes with Parsley Cream Sauce (F) **or** Broiled Steak (S) Buttered Diced Potatoes (FS) Julienne Green Beans (FS) **or** Brussels Sprouts Sliced Tomato and Lettuce with Mayonnaise **or** Deviled Eggs Baked Apple (S) with Nutmeg Sauce (F) **or** Rainbow Gelatin with Custard Sauce
saturday	Orange Juice (FS) **or** Grapefruit Juice Refined Wheat Cereal **or** Puffed Rice Cereal Fried Egg Bacon	Pineapple Juice Roast Veal with Gravy (FS) **or** Lima Beans with Ham Hocks Whipped Potatoes (S) Candied Carrots (FS) **or** Stewed Okra Orange, Bermuda Onion Slices on Lettuce **or** Cream Cheese with Stuffed Celery Biscuits Deep Dish Cherry Pie (F) **or** Peeled Apricots in Syrup (S)	Vegetable Soup Meat Loaf with Tomato Sauce (FS) **or** Corned Beef with Mustard Boiled Whole Potato (FS) Buttered Asparagus (FS) **or** Seven-Minute Cabbage Banana Log Salad **or** Lettuce Wedge with Thousand Island Dressing Peanut Butter Cookie (F) **or** Butterscotch Pudding (S)
sunday	Tangerine (F) **or** Peach Nectar (S) Refined Wheat Cereal **or** Ready-to-Eat Sugar Frosted Cereal Sausage Links Waffles and Syrup	Split Pea Soup Fried Chicken with Cream Gravy (F) **or** Braised Beef Cubes (S) Buttered Rice (FS) Eggplant Au Gratin (F) **or** Buttered Spinach (S) Cherry Pecan Gelatin **or** Vegetable and Cottage Cheese with Olive Garnish Hot Rolls Peach Half in Syrup (FS) **or** Vanilla Ice Cream	Cream of Potato Soup Creamed Chipped Beef and Mushrooms on Rusk (FS) **or** Roast Beef with Gravy Potato Puffs Buttered Whole Beets (FS) **or** Escalloped Tomatoes Chef's Salad with French Dressing **or** Mixed Citrus Salad with Cherry Garnish Heavenly Hash (FS) **or** Butterscotch Brownies

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Brisket, Corned (Boneless)	U. S. Good	7 lbs.	20
Chipped Beef, Dried	U. S. Good	4 lbs.	60
Ground Beef	U. S. Good, 5 lb. pkg.	55 lbs.	
Liver	Steer, sliced	20 lbs.	80
Round (Top, Boneless)	U. S. Good	27 lbs.	80
Steaks, Cubed	U. S. Choice, 4 oz. each	5 lbs.	20
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	6 lbs. 4 oz.	20
Stew	U. S. Good	25 lbs.	100
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	5 lbs.	
Ham (Pullman)	Ready-to-eat	4 lbs.	
Ham Hocks		20 lbs.	40
Loin (Boneless)	Grade A, 10-12 lbs.	20 lbs.	60
Sausage Links	12-1 lb.	20 lbs.	
VEAL			
Cutlets	U. S. Good, 4 oz. each	10 lbs.	40
Leg (B.R.T.)	U. S. Good	27 lbs.	80
FISH			
Halibut	Steaks, 5 oz. each	25 lbs.	80
Oysters	Gallon, Stand.	3 qts.	

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	30 lbs.	40
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.	80
Fryers (Eviscerated)	Grade A, 2½ lb. av.	75 lbs.	100
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	20 lbs.	
Grapefruit, Pinkmeat	Seedless, 70s	½ box	
Lemons		1 doz.	
Oranges	176s	5 doz.	
Tangerines	Crate, 144	½ crate	
FRESH VEGETABLES			
Cabbage	Bag	21 lbs.	
Carrots	Topped, bag	75 lbs.	
Celery	Pascal, 30s	1 doz.	
Cucumbers		4 cukes	
Eggplant		14 lbs.	
Escarole		2 heads	
Lettuce	Head, 48s	1 crate	
Okra		4 lbs.	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Bermuda		6 lbs.	
Parsley	Bunch	1 doz.	
Pepper, Green		5 lbs.	

Item, Specifications, Amounts & No. of Servings			
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		10 heads	
Squash, Acorn		8	
Tomatoes	Repacked (5 x 6)	16 lbs.	
FROZEN FRUITS			
Grapefruit Juice	Con., 32 oz. can	1 can	
Grapefruit Sections	Fresh, chilled, gallon	1 gal.	
Orange and Grapefruit Sections	Fresh, chilled, gal.	2 gal.	
Orange Juice	Con., 32 oz. can	11 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	1 can	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	20 lbs.	120
Beans, Green	Cuts, 2½ lb. pkg.	17½ lbs.	105
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Broccoli	Stems and buds 2½ lb. pkg.	15 lbs.	90
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	25 lbs.	145
Spinach	Chopped, 2½ lb. pkg.	27½ lbs.	165
Turnip Greens	2½ lb. pkg.	10 lbs.	60

PLEASE CUT ALONG THIS LINE

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2nd WEEK SOUTH-SOUTHWEST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Frances Hoffman, administrative dietitian Women and Children's Hospital, Baylor University Medical Center, Dallas, Tex.

PLEASE CUT ALONG THIS LINE

	morning	noon	night
monday	Orange Juice (FS) or Baked Apple Grits or Ready-to-Eat Rice Cereal Soft Boiled Egg Doughnut	Beef Gumbo Soup Country Fried Steak with Gravy (F) or Creamed Chicken on Toast Points (S) Oven Browned Potatoes Squash with Onion and Bacon (F) or Buttered Green Beans (S) Chinese Cabbage Salad with Tomato Wedge and Mayonnaise or Cranberry Relish Salad Chocolate Pudding with Whipped Cream (FS) or Sliced Bananas	Cream of Mushroom Soup Beef Biscuit Roll with Gravy (F) or Baked Veal Cutlet with Gravy (S) Duchess Potatoes (S) Bavarian Spinach (F) or Buttered Carrot Coins (S) Stuffed Prunes with Cream Cheese or Celery, Carrot and Pickle Sticks with Ripe Olives Baked Pear (S) with Honey Ginger Glaze (F) or Sugar Cookies
tuesday	Pear Nectar (FS) or Stewed Prunes Oatmeal or Ready-to-Eat Crisp Corn Cereal Scrambled Egg Biscuits and Honey	Orange Juice Baked Ham with Red-Eye Gravy (F) or Escalloped Tuna and Noodle Casserole (S) Candied Sweet Potatoes (F) Frozen Black-Eyed Peas (F) or Buttered Asparagus (S) Sliced Tomato and Lettuce with Mayonnaise or Sliced Peaches and Figs in Raspberry Gelatin Cornbread Muffin Pineapple Upside-Down Cake (F) or Baked Custard (S)	Cream of Pea Soup Salisbury Steak (FS) or Roast Lamb with Gravy Escalloped Potatoes (FS) Baked Squash (FS) or Fried Eggplant Tossed Salad with Oil and Vinegar or Grapefruit Half with Cherry Garnish Graham Cracker Torte (FS) or Minted Pineapple Tidbits
wednesday	Spicy Applesauce (F) or Orange Juice (S) Refined Wheat Cereal or Ready-to-Eat Wheat Flakes Poached Egg Bacon	Beef Barley Soup Turkey Turnovers with Parsley Cream Sauce (F) or Broiled Beef Patty in Bacon Ring (S) Baked Potato Stewed Tomatoes (F) or Seasoned Green Beans (S) Strawberry Gelatin with Cottage Cheese or Coleslaw Golden Cupcake with Butter Frosting (F) or Peeled Apricot Halves	Cream of Spinach Soup Old Fashioned Beef Stew (F) or Broiled Chicken in Lemon Butter (S) Buttered Whole Potato (FS) Lemon Buttered Broccoli (F) or English Peas in Cream Sauce (S) Pear Half with Cream Cheese Frosting and Tokay Grapes or Shredded Lettuce with Thousand Island Dressing Peach Crisp (F) or Royal Anne Cherries (S)
thursday	Orange Fingers (F) or Grape Juice (S) Cooked Wheat Cereal or Ready-to-Eat Crisp Corn Cereal Scrambled Eggs Honey Butter Toast	Cream of Tomato Soup (S) Roast Beef Au Jus (FS) or Creamed Ham on Cornbread Mashed Potatoes (FS) Buttered Asparagus (FS) or Paprika Cauliflower Peach Half with Prune or Pickle, Celery Sticks with Tomato Wedge, Half Deviled Egg Hot Rolls Nutmeg Feather Cake with Nutmeg Frosting (F) or Chocolate Pudding (S)	Orange and Grapefruit Juice Smothered Liver (S) and Onions (F) or Eggs Goldenrod on Rusk Buttered Diced Potatoes (FS) Corn Pudding (F) or Buttered Whole Beets (S) Pineapple Slice with Cottage Cheese — Cherry Garnish or Chef's Salad with French Dressing English Apple Pie (F) or Fruit Cocktail (S)
friday	Grapefruit Juice (FS) or Sliced Bananas Refined Wheat Cereal or Ready-to-Eat Bran Cereal Soft Boiled Eggs Cinnamon Roll	Clam Chowder Fried Catfish with Tartar Sauce (F) or Macaroni and Cheese (S) Escalloped Potatoes (F) Buttered Frozen Spinach (FS) or Stewed Tomatoes Mexican Coleslaw or Canned Fruit Salad with Harlequin Dressing Bran Muffin Orange Coconut Custard (F) or Peach Half in Syrup (S)	Cream of Potato Soup Tuna Loaf with Egg Sauce (FS) or Barbecued Beef Mashed Potatoes (FS) Buttered Carrot Coins (FS) or Baked Beans Grapefruit, Avocado in Lime Gelatin or Sliced Tomatoes and Lettuce with Mayonnaise Orange Sherbet (FS) or Kadota Figs
saturday	Orange Juice (FS) or Stewed Apricots Oatmeal or Puffed Rice Cereal Scrambled Egg Bacon	Cream of Chicken Soup Broiled Loin Pork Chop (F) or Roast Veal with Gravy (S) Steamed Potato in Skin Buttered Asparagus (FS) or Fried Okra Ambrosia Salad or Tossed Green Salad with Russian Dressing Tapioca Pudding (FS) or Chocolate Cake with Fudge Icing	Consomme Smothered Steak (F) or Beef Rice Casserole (S) Lyonnaise Potatoes (F) or Buttered Diced Potatoes (S) Buttered Frozen Peas (FS) or Glazed Parsnips Pineapple Surprise Salad or Chinese Cabbage with Oil and Vinegar Dressing Emerald Isle Fluff (F) or Applesauce (S)
sunday	Grapefruit Half (F) or Pineapple Juice (S) Cooked Wheat Cereal or Ready-to-Eat Wheat Flakes Poached Egg Raisin Toast	Vegetable Soup Chicken Divan (F) or Broiled Steak (S) Whipped Potatoes (FS) Baked Acorn Squash (FS) or Stewed Tomatoes Cranberry Relish Salad in Raspberry Gelatin or Spiced Peach Salad Hot Rolls Ginger Creams (F) or Mixed Fruit Cup (S)	Beef Barley Soup Beef Pot Pie (F) or Lamb Patty with Mint Jelly (S) Baked Potato (S) Seasoned Green Beans (FS) or Creamed Celery and Mushrooms Lettuce Wedge with French Dressing or Pear Half with Prune Garnish Chocolate Ice Cream (FS) or Sliced Bananas with Cream

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Chuck-eye Roll (Boneless)	U. S. Good	34 lbs.	100
Ground Beef	U. S. Good, 5 lb. pkg.	35 lbs.	
Liver	Steer, sliced	15 lbs.	60
Round (Top, Boneless)	U. S. Good	27 lbs.	80
Steaks, Cubed	U. S. Choice, 4 oz. each	25 lbs.	100
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	16 lbs. 4 oz.	20
Steak, Swiss	U. S. Good, 4 oz. each	15 lbs.	60
Stew	U. S. Good	15 lbs.	60
LAMB			
Ground, Shoulder	U. S. Good	5 lbs.	20
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	5 lbs.	
Chops, Loin	Grade A, 4 oz. each	25 lbs.	100
Ham (Pullman)	Ready-to-eat	47 lbs.	140
VEAL			
Cutlets	U. S. Good, 4 oz. each	5 lbs.	20
Leg (B.R.T.)	U. S. Good	7 lbs.	20
FISH			
Catfish		50 lbs.	

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	90 lbs.	120
Fryers (Eviscerated)	Grade A, 2 lb. av.	15 lbs.	20
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	75 lbs.	100
FRESH FRUITS			
Apples	Baking, 113s	7 lbs.	
Avocado	Ripe	6	
Bananas	Ripe	27 lbs.	
Grapefruit	Seedless, 70s	1 box	
Grapes	Tokay	10 lbs.	
Lemons		1 doz.	
Oranges	176s	5 doz.	
FRESH VEGETABLES			
Cabbage	Bag	20 lbs.	
Carrots	Topped, bag	53 lbs.	
Celery	Pascal, 30s	1 doz.	
Chinese Cabbage		8 heads	
Eggplant		3	
Lettuce	Head, 48s	1 crate	
Okra		4 lbs.	
Onions, Dry	Yellow, bag	50 lbs.	
Parsley	Bunch	1 doz.	
Parsnips		5 lbs.	
Pepper, Green		4 lbs.	

Item, Specifications, Amounts & No. of Servings			
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	1 doz.	
Romaine		10 heads	
Squash, Acorn	Bushel	1½ bu.	
Tomatoes	Repacked (5 x 6)	23 lbs.	
FROZEN FRUITS			
Grapefruit Juice	Con., 32 oz. can	3 cans	
Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Orange Juice	Con., 32 oz. can	10 cans	
Orange and Grapefruit Juice	Con., 32 oz. can	2 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	32½ lbs.	195
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Black-Eyed Peas		15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	10 lbs.	60
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	12½ lbs.	75
Spinach	Chopped, 2½ lb. pkg.	35 lbs.	210
Squash, Patty Pan	3 lb. pkg.,	24 lbs.	90

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3rd WEEK SOUTH-SOUTHWEST SELECTIVE WINTER CYCLE MENU

(MENUS TO BE USED DURING DECEMBER, JANUARY AND FEBRUARY)

—prepared by Frances Hoffman, administrative dietitian Women and Children's Hospital, Baylor University Medical Center, Dallas, Tex.

	morning	noon	night
monday	Orange Juice (FS) or Grape Juice Refined Wheat Cereal or Ready-to-Eat Wheat Flakes Scrambled Egg Bacon	Tomato Rice Soup Stuffed Pork Chops with Gravy (F) or Braised Beef Cubes (S) Buttered Whole Potatoes (S) with Chopped Parsley (F) Succotash (F) or Julienne Carrots (S) Tomato Aspic or Apple, Celery Salad Coconut Macaroons (F) or Rice Pudding (S)	Consomme Julienne Meat Loaf with Catsup (FS) or Country Fried Steak with Gravy Baked Potato (FS) Asparagus au Gratin (FS) or Parsley Buttered Onions Citrus Salad or Lettuce Wedge with Thousand Island Dressing Spice Bars with Lemon Frosting (F) or Peeled Apricots in Syrup (S)
tuesday	Sliced Bananas (FS) or Orange Juice Cooked Rolled Wheat Cereal or Ready-to-Eat Corn Cereal Poached Egg Biscuits with Jelly	Cream of Pea Soup Texas Hash (F) or Broiled Chicken (S) Whipped Potatoes (S) Lemon Broccoli (F) or Buttered Whole Beets (S) Pear Half with Grated Cheese or Chef's Salad with Chiffonade Dressing Deep Dish Peach Pie (F) or Fruit Cocktail (S)	Cranberry Juice Cocktail Roast Beef with Gravy (FS) or Baked Stuffed Frankfurters Au Gratin Potatoes (FS) Buttered Spinach (FS) or Corn Pudding Carrot and Raisin Salad or Sliced Tomato and Lettuce Hot Rolls Banana Pudding (FS) or Sliced Pineapple
wednesday	Stewed Prunes (F) or Orange Juice (S) Buttered Rice with Brown Sugar or Ready-to-Eat Wheat Flake Cereal Soft Boiled Egg Bacon	Tomato Juice Chicken Fricassee (FS) or Broiled Beef Patty Mashed Potatoes (FS) Buttered Peas (FS) or Stewed Okra and Tomatoes Apricots with Cream Cheese or Chinese Cabbage with Thousand Island Dressing Cranberry Crunch (F) or Baked Apple (S)	Cream of Celery Soup Cheese Souffle (FS) or Swiss Steak Steamed Potatoes in Skins (FS) Buttered Asparagus (FS) or Parslied Cauliflower Celery, Tokay Grapes and Marshmallow Salad or Tossed Green Salad with Roquefort Dressing Orange Bran Muffin (F) Chocolate Cake with Chocolate Pecan Frosting (F) or Peach Slices (S)
thursday	Orange Fingers (F) or Pear Nectar (S) Grits or Ready-to-Eat Sugar Frosted Cereal Scrambled Egg Quick Coffee Cake	Chicken Noodle Soup Chop Suey (F) or Roast Lamb with Mint Jelly (S) Buttered Steamed Rice (FS) Seasoned Green Beans (FS) or Baked Squash Banana Log Salad or Lettuce, Tomato and Celery Salad with Mayonnaise Cherry Pie (F) or Pear Half (S)	Tomato Juice Baked Chicken with Gravy (FS) or Meat Balls in Mushroom Gravy Whipped Potatoes (FS) Broccoli Au Gratin (F) or Buttered Diced Beets (S) Golden Glow Salad or Lettuce Wedge with Olive Garnish and French Dressing Honey Nut Muffin Butterscotch Pudding (FS) or Tangerine
friday	Grapefruit Juice (FS) or Orange Juice Oatmeal or Ready-to-Eat Rice Cereal Poached Egg	Seafood Gumbo Soup Baked Cod with Tartar Sauce (FS) or Veal Birds with Gravy Buttered Diced Potatoes (S) with Parsley (F) Buttered Baby Lima Beans (F) or Buttered Carrots (S) Tossed Green Salad with Russian Dressing or Orange Slices with Raisin Garnish Lazy Daisy Cake (F) or Canned Fruit Cup (S)	Cream of Asparagus Soup Smothered Steak (F) or Escalloped Tuna and Noodles (S) Mashed Potatoes (F) Braised Crisp Celery (F) or Lemon Buttered Beets (S) Peanut Coleslaw or Canned Fruit Salad with Honey Dressing Apple Brown Betty (F) or Sliced Bananas (S)
saturday	Apple Juice (FS) or Orange Juice Refined Wheat Cereal or Puffed Wheat Scrambled Egg Bacon Pancakes with Syrup	Vegetable Soup Roast Beef Au Jus (FS) or Hamburger with Bun — Mustard and Relish Baked Potato (FS) Buttered Spinach (FS) or Buttered Diced Ruatabga. Gingerale Salad or Sliced Tomatoes and Onions on Lettuce Hot Rolls Strawberry Bavarian (F) or Royal Anne Cherries (S)	Mixed Fruit Juice Chicken and Dumplings (F) or Braised Liver (S) Creamed Potatoes (S) Buttered Green Beans (FS) or Steamed Seven-Minute Cabbage Spiced Peach Salad or Sliced Pineapple with Cottage Cheese Burnt Sugar Cake with Burnt Sugar Butter Frosting (FS) or Kadota Figs
sunday	Orange Juice (FS) or Mixed Dried Fruit Compote Cooked Wheat Cereal or Ready-to-Eat Wheat Flake Cereal Soft Boiled Egg Cinnamon Toast	Cream of Corn Soup Baked Ham with Raisin Sauce (F) or Broiled Chicken (S) Baked Sweet Potato (F) or Whipped Potatoes (S) Buttered Diced Carrots and Peas (FS) or Dutch Greens Jellied Vegetable Salad with Mayonnaise or Shredded Lettuce with French Dressing Hot Rolls Lemon Ice Box Pie (F) or Soft Fruit Cups (S)	Chicken Noodle Soup Beef Stew (F) or Broiled Steak (S) Escalloped Potatoes (S) Lemon Buttered Broccoli (F) or Buttered Squash (S) Stuffed Celery with Chive Cheese or Blushing Pear Lime Sherbet (FS) or Fresh Apple

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	65 lbs.	
Liver	Steer, sliced	5 lbs.	20
Rump (Boneless)	U. S. Good	47 lbs.	140
Steaks, Cubed	U. S. Choice, 4 oz. each	5 lbs.	20
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	6 lbs. 4 oz.	20
Steak, Swiss	U. S. Good, 4 oz. each	20 lbs.	80
Stew	U. S. Good	20 lbs.	80
LAMB			
Leg (B.R.T.)	U. S. Choice, yearling	7 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	15 lbs.	
Chops, Loin	Grade A, 4 oz. each	25 lbs.	100
Ham (Pullman)	Ready-to-eat	34 lbs.	100
PREPARED MEATS			
Frankfurters	10-1 lb.	4 lbs.	20
VEAL			
Chop Suey Meat	U. S. Good	25 lbs.	100
Shoulder (Boneless)	U. S. Good	14 lbs.	40
FISH			
Cod	Fillets, Canadian	20 lbs.	80

Item, Specifications, Amounts & No. of Servings			
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	105 lbs.	140
Fryers (Eviscerated)	Grade A, 2 lb. av.	30 lbs.	40
Fryers (Eviscerated)	Grade A, 2½ lb. av.	45 lbs.	60
FRESH FRUITS			
Apples	Baking, 113s	7 lbs.	
Apples	Jonathan, 113s	¾ box	
Bananas	Ripe	60 lbs.	
Grapes	Tokay	10 lbs.	
Lemons		1 doz.	
Oranges	176s	8 doz.	
Tangerines	Crate, 144	2 doz.	
FRESH VEGETABLES			
Cabbage	Bag	11 lbs.	
Carrots	Topped, bag	21 lbs.	
Celery	Pascal, 30s	1 doz.	
Chinese Cabbage		4 heads	
Lettuce	Head, 48s	1 crate	
Okra		4 lbs.	
Onions, Dry	Yellow, bag	50 lbs.	
Parsley	Bunch	1 doz.	
Pepper, Green		3 lbs.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	

Item, Specifications, Amounts & No. of Servings			
Radishes	Bunch	1 doz.	
Romaine		7 heads	
Tomatoes	Repacked (5 x 6)	21 lbs.	
Turnips, Yellow		5 lbs.	
FROZEN FRUITS			
Grapefruit Juice	Con., 32 oz. can	3 cans	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
Orange Juice	Con., 32 oz. can	8 cans	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	2 cans	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	10 lbs.	60
Asparagus	Spears, 2½ lb. pkg.	20 lbs.	120
Beans, Green	Cuts, 2½ lb. pkg.	25 lbs.	150
Beans, Lima	Small, green 2½ lb. pkg.	15 lbs.	90
Broccoli	Stems and buds 2½ lb. pkg.	35 lbs.	210
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Greens, Mixed	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	15 lbs.	90
Peas and Carrots	2½ lb. pkg.	15 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Squash, Winter	1 lb. pkg.	8 lbs.	30
Succotash	2½ lb. pkg.	15 lbs.	90

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Naturally nutritious oatmeal provides high protein thiamine and iron

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Oatmeal is not only valuable as a nutritious breakfast food, but also for the in-between nourishment patients need to help speed recovery.

One ounce of Quaker Oats provides the following percentages of adult M.D.R.: Thiamine (vitamin B_1) 16.5%, phosphorus 16.5% and iron 11.0%. Each ounce also provides 110 calories, 6.9% fat, 62.4% carbohydrates, and 1.5% non-nutritive crude fiber.

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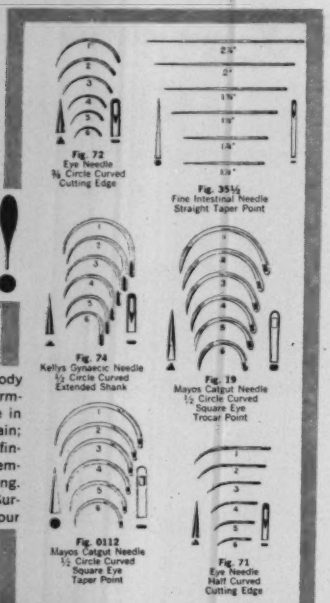

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personnel changes

● **Omer B. Maphis** has announced his retirement from the field of hospital administration. The administrator of Greene Memorial Hospital, Xenia, Ohio, for the past 11 years, Mr. Maphis began his administrative career as administrator of Bethany Sanitarium and Hospital, Chicago, in 1924. His many positions in the hospital field include assistant administrator of Norwegian American Hospital, Chicago, administrator of Deaconess Hospital, Freeport, Ill., and administrator of Kenosha (Wis.) Hospital.

Mr. Maphis served as a member of the board of directors of the American Protestant Hospital Association and as a member of the executive committee of the Wisconsin Blue Cross Organization.

● **Thomas J. Markson** is the new assistant administrator of St. Luke's Hospital, St. Paul. He is a 1961 graduate of the University of Minnesota course in hospital administration. Mr. Markson served his administrative residency at St. Luke's Hospital in Duluth, Minn.

● **Boone Powell Jr.** has accepted the position of assistant administrator of Hendrick Memorial Hospital, Abilene, Tex. He holds a bachelor's degree in business administration from Baylor University, and a master's in hospital administration from the University of California. Mr. Powell served his residency at the Baptist Memorial Hospital, Memphis, Tenn.

● **Thomas A. Rose** has been appointed assistant director of Cleveland Metropolitan General Hospital. A graduate of the hospital administration program of the University of Minnesota, Mr. Rose for the past six years has been assistant executive secretary of the Cleveland Hospital Council.

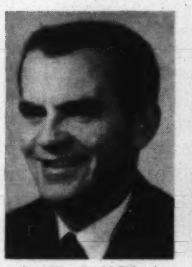
● **Solomon L. Siegel** is the new assistant executive director of Maimonides Hospital of Brooklyn, N.Y. He was formerly an associate executive director at the Jewish Chronic Disease Hospital in Brooklyn. Mr. Siegel is a graduate of the City College Baruch School of Business Administration and Teachers' College at Columbia University. He is a past president of the American Association of Hospital Purchasing Agents.

● **William A. Stewart** has been named assistant administrator of Riverside Hospital, Toledo, Ohio. Mr. Stewart has been assistant administrator of Little Traverse Hospital, Petoskey, Mich., since March 1960, and previously was administrator of Orange County Hospital, Paoli, Ind. He is a graduate of Ball State Teachers College, Muncie, Ind., and holds a master's degree in hospital administration from Northwestern University.

● **Sister Alma Cordo,** former business manager of Maryknoll Hospital, Monrovia, Calif., has been named as the hospital's new administrator. She is a graduate of the St. Louis University course in hospital admin-

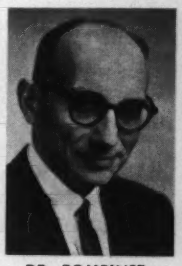
istration and replaces Sister Maura Magdalen who will pursue studies at St. Louis University.

● **Andrew Talley** has become the administrator of Grady Memorial Hospital, Chickasha, Okla. Mr. Talley is immediate past president of the Arkansas Hospital Association. His new position was effective June 26.



MR. TALLEY

MR. SISSELMAN



DR. POMRINSE

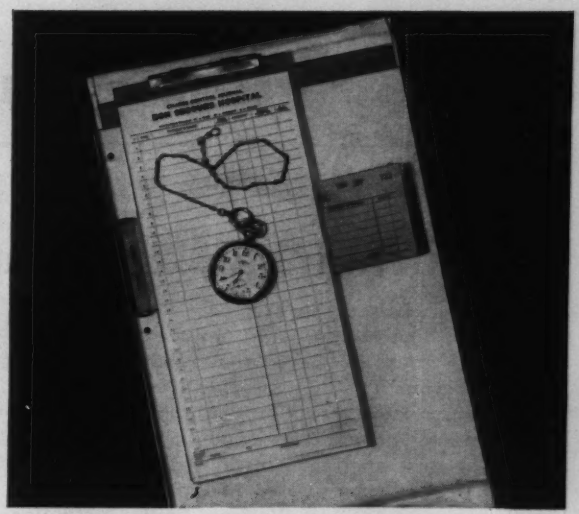
● **Milton H. Sisselman** and **S. David Pomrinse, M.D.,** have been appointed associate directors of the Mount Sinai Hospital, New York. Mr. Sisselman came to the hospital as an administrative assistant in 1952, and has served as assistant director for the past seven years. He holds a degree in hospital administration from Yale University. Dr. Pomrinse was formerly a medical director with the U.S. Public Health Service. He is a graduate of the Rensselaer Polytechnic Institute, Western Reserve Medical College and the Columbia University School of Public Health and Administrative Medicine.

● **Sister Rose Miriam, O.S.B.,** has been appointed administrator of the Benedictine Heights Hospital, Guthrie, Okla. She replaces **Sister Mary Cornelia, O.S.B.,** who will return to college for additional studies in the hospital field. Sister Rose Miriam has completed special training in hospital administration at St. Louis University.

● **Billy R. Talbert,** formerly administrator of Clinton (Mo.) General Hospital, has assumed new duties as assistant administrator of Blessing Hospital, Quincy, Ill. He succeeds **Jerry E. Poole,** who recently accepted a position as administrator of Brokaw Hospital, Normal, Ill. Mr. Talbert is a graduate of the course in hospital administration at Northwestern University.

● **R. J. Weinzettel** has been appointed administrator of the Memorial Hospital of Chatham County, Savannah, Ga., effective September 1. Mr. Weinzettel has served as administrator of Memorial Hospital, Waycross, Ga., for the past six years. He received his master's degree in hospital administration from Northwestern University.

● **Harold W. Wicks** has taken a new position as assistant director of Pittsfield General Hospital, after completing residency training at Thayer Hospital, Waterville, Maine. He is a graduate of Yale University with a master's degree in public health.



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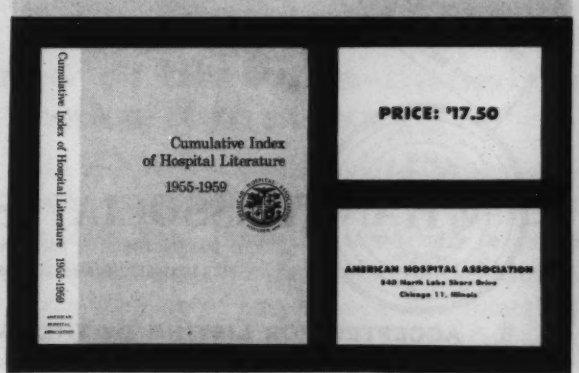
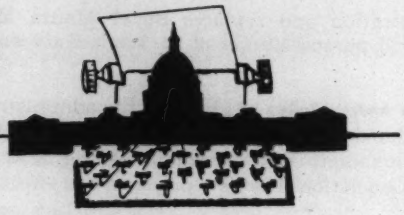


WASHINGTON REPORT



Hill-Burton Nursing Home Funds Increased

Passed just before the predawn adjournment of Congress on September 27, the supplemental "catch-all" appropriations bill gave added funds to the Hill-Burton program. The increase was $8.5 million, and it is for construction grants for nonprofit and publicly owned nursing homes. This makes a total of $18.5 million for this program in fiscal year 1962 because $10 million was appropriated in the Department of Health, Education, and Welfare funds legislation passed earlier in the month. The increase was authorized in the Community Health Services and Facilities Act of 1961, approved subsequent to passage of the HEW appropriations measure. It raised the ceiling for the nursing home grants from $10 million to $20 million per year.

The total appropriation for the Hill-Burton program in fiscal year 1962 thus became $211.5 million. It will be allocated as follows: $150 million for Part C construction projects for hospitals and health centers; $59,728,000 for Part G construction projects for nursing homes, diagnostic and treatment centers, rehabilitation facilities and chronic disease hospitals, and $1,772,000 for administrative expenses.

The Community Facilities Act authorized a $10 million yearly hospital research facilities program as an amendment to the Hill-Burton legislation. Grants will be made by the U.S. Public Health Surgeon General and will not be subject to the state and local community administrative regulations governing Hill-Burton Part C and Part G construction projects. The $10 million for the new research facilities program was appropriated in the HEW funds bill.

The Community Facilities Act also established a $10 million annual program for grants to states or other public or nonprofit agencies for studies, experiments and demonstrations to develop new or improved methods of health care outside the hospital, particularly for the aged and chronically ill. The supplemental appropriations legislation included $7 million for this program in fiscal year 1962. The $7

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"Haney Associates did magnificent job of organizing campaign and following through on multitude of details. Dr. Haney's inspirational talk at kickoff dinner set tone for workers and they never waivered until job was done. We went well over $200,000 goal, and we may reach $300,000 when all returns are in.

"This feat more impressive because community never before had been asked to contribute to hospital in 35 years of its existence. Our job was to convince a skeptical community that a new hospital was vital and their money necessary. We are sure that professional touch of Haney Associates was difference between success and failure of campaign."

Joseph J. DeLuccia, Chairman
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He's the Man Behind the Huntington Drum (our representative). And his recommendations for a Patient-Safety Program are helping protect everyone in this nursery from cross infection. The program is based on his years of experience and a multitude of sanitation products especially created to meet the aseptic requirements of hospitals. Read about this important program on the next page. It's the common-sense solution to the problem of hospital-acquired infection.

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How to prevent infection from originating in the hospital. That's the problem. Many hospitals are solving it by returning to old-fashioned attitudes toward cleanliness in every department combined with the use of modern, efficient aseptic products. And they are adopting the basic principles of a Patient-Safety Program to set up a common-sense plan-of-attack against resistant Staph. and all other infectious agents.

This practical program features:

- More than 100 Huntington products that will effectively help combat the spread of infection from the admitting office to the O.R. suite, the nursery, everywhere in the hospital.
- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

Call or write today. Get more details on the Huntington Patient-Safety Program.

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million is in addition to $3,958,000 in the HEW funds measure for similar type projects under the classification of chronic diseases and health of the aged.

The supplemental appropriations bill also increased the funds available for loans for rental housing projects for the elderly. It added $35 million. Since $25 million was appropriated in the housing agency funds legislation passed in August, the total amount appropriated this year is $60 million. Last year $20 million was appropriated, making a cumulative total of $80 million. The ceiling for this program was increased from $50 million to $125 million in the Housing Act of 1961. As of September 15, the Housing and Home Finance Agency, which administers the program, had made firm commitments for 32 rental projects involving $21 million.

Community Facilities Act Redefines "Rehabilitation Facility"

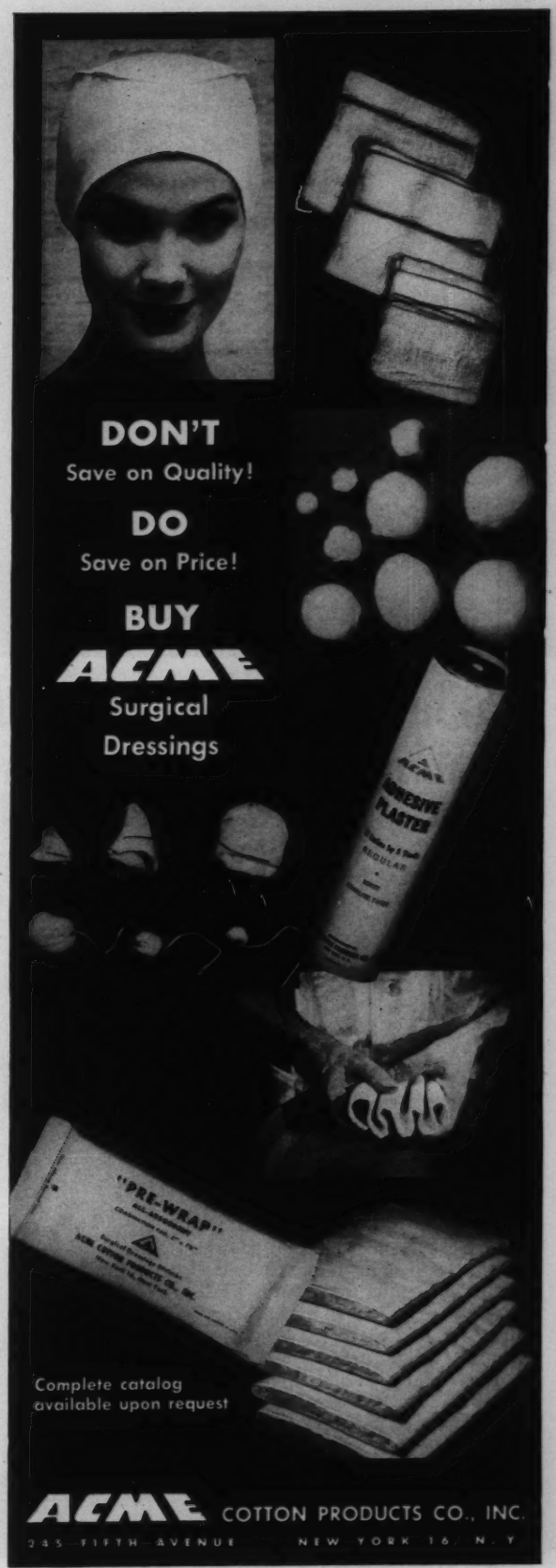
Among other provisions in the Community Health Services and Facilities Act of 1961 is a revision of the definition of "rehabilitation facility" in Hill-Burton Part G construction projects. As stated in the House-Senate conference committee report on the bill, it is now provided that the term "means a facility operated for rehabilitation of disabled persons through a program of medical evaluation and services, and at least one of the following programs: Psychological, social, or vocational evaluation and services". This was a Senate amendment after initial House passage of the bill. Previously the law had required that a rehabilitation facility provide all four of the listed programs. The conference report stated that the House members agreed to inclusion of the Senate amendment "since rehabilitation services can make a significant contribution to a coordinated program of out-of-hospital medical services".

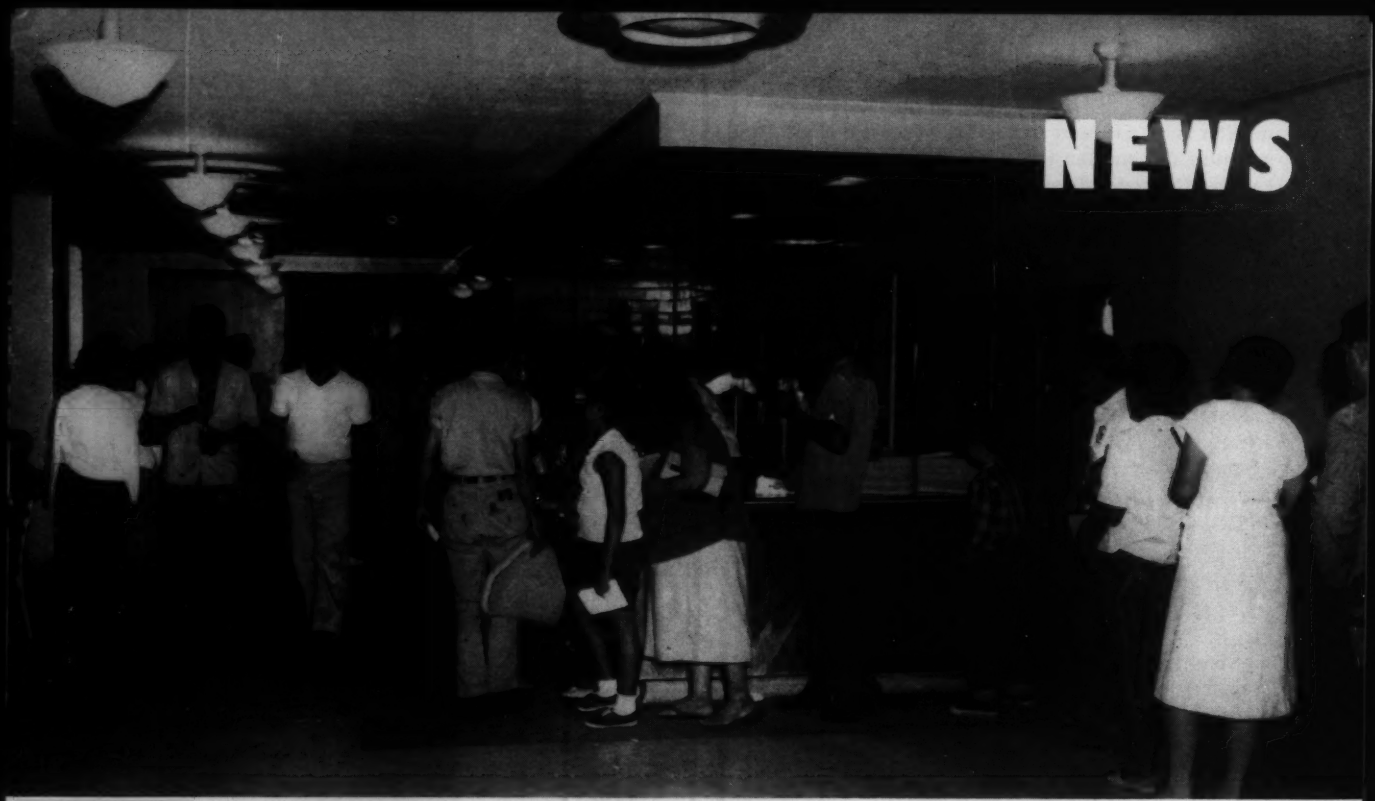
The Community Facilities Act also increased the ceiling for the health research facilities construction program. It is now $50 million instead of $30 million a year.

Anti-discrimination Hospital Bill Introduced

In the closing days of the 1961 Congressional session, Sen. Jacob Javits (R-N.Y.) introduced a bill to amend the Hill-Burton Act to prohibit discrimination in hospital facilities. The bill proposes in part "that before approval of any application for a hospital or addition to a hospital is recommended by a state agency, assurance shall be received by the state from the applicant that . . . such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination in any respect whatsoever on account of race, creed, or color."

The bill, S.2625, was referred to the Senate Committee on Labor and Public Welfare. No preadjournment action was taken by the committee, leaving the measure pending for possible consideration when Congress reconvenes.





Carla: Severe Test for Texas Hospitals

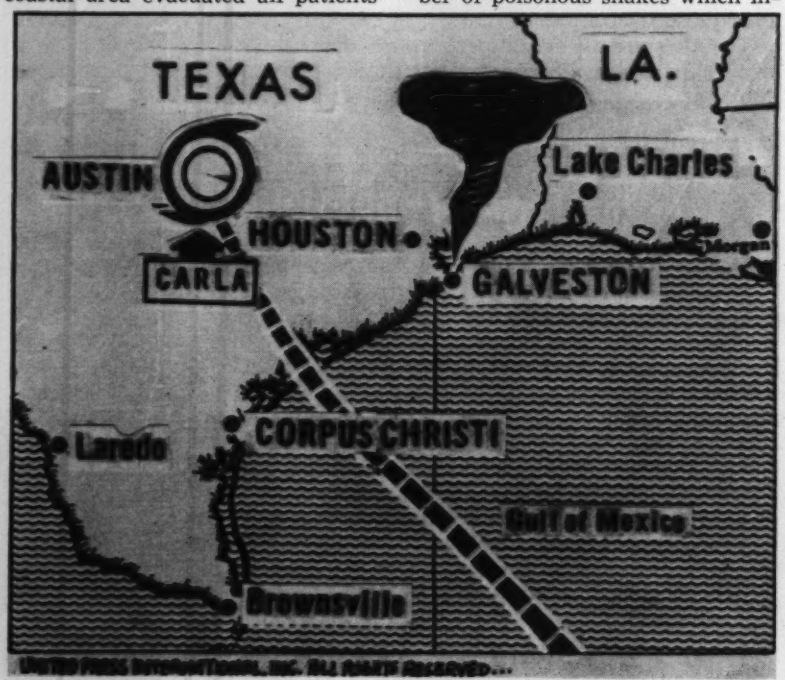
Despite Crippled Facilities, Hospitals Keep Doors Open to Patients, Evacuees

When the full force of Hurricane Carla hit the crescent-shaped Gulf Coast of Texas, September 10 and 11, hospitals in the path of the storm faced their biggest test in 60 years—and passed with honors.

- Some hospitals in the 500-mile coastal area evacuated all patients to inland hospitals; others carried out partial evacuation and remained on stand-by alert, while a few put full disaster plans into effect and rode out the entire violent storm.
- Hospitals further inland housed and fed hundreds of temporarily homeless evacuees and cared for evacuated coastal-area hospital patients.
- Hospital personnel worked around the clock to keep hospitals operating effectively despite food shortages, water pollution, power failure, wind damage and flooding.

The hurricane, one of the wildest in history, raged up the coast from Corpus Christi, Tex., to Morgan City, La. With winds estimated up to 170 miles an hour in velocity, it spawned tornadoes which resulted in two dozen known deaths, caused property and crop damage that will likely run to $500 million and drove 300,000 (Red Cross estimate) to 500,000 people (civil defense estimate) back from the shipping-fishing-resort-oil centers along the coast.

Most hospitals affected by the hurricane had a 24-hour warning —enough time to stockpile such things as food, fresh water and dry ice. Snake bite serum was also stocked because of the large number of poisonous snakes which in-



◀ **EVACUEES AND hospital personnel wait in the John Sealy Hospital cafeteria for one of many meals served by the hospital during Hurricane Carla. The hospital fed an estimated 4500 persons for almost three full days. When electrical power failed, 6000 to 8000 sandwiches were made for each meal.**

vade populated areas during heavy rains.

O. Ray Hurst, Texas Hospital Association executive director, reported that preliminary plans had been made in cooperation with the Texas Medical Association to keep doctors in storm-free areas on a stand-by alert in case they were needed in critical areas. He also reported that discussions were held with civil defense officials on the state-wide availability of hospital beds should further evacuation of hospitals have become necessary.

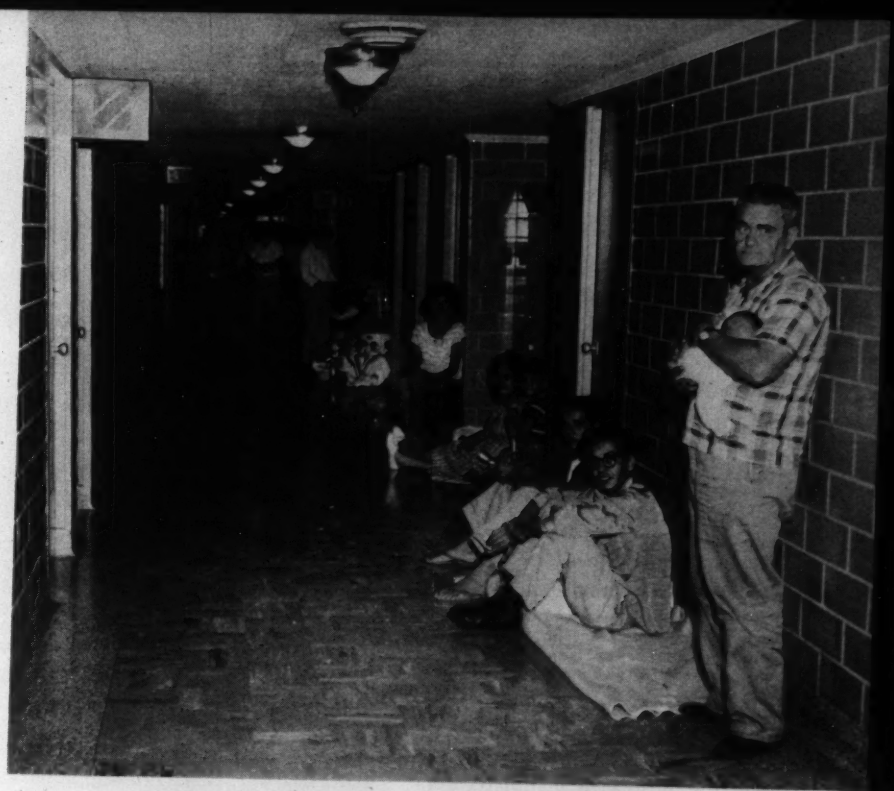
Many refugees from the coast went to San Antonio, well inland and 250 miles northwest of Galveston, to escape the big blow. Civil defense headquarters in San Antonio were manned on a full-time basis by police and fire department officers, with the Red Cross coordinating the efforts of hospitals and other voluntary organizations. Red Cross brought in personnel from all over the South and Midwest—from as far away as Detroit—to assist in the disaster areas.

D. A. Garrett, administrator of San Antonio's 290-bed Baptist Memorial Hospital, reported that the hospital admitted 10 to 15 evacuees from Calhoun County Memorial Hospital in Port Lavaca, Tex. Mr. Garrett said that his institution is a "five-day-week hospital" with a low week-end census, and that on the Monday, when the hurricane hit the shore, sufficient beds were available for more evacuees than the hospital had to handle. The hospital put its staff on a stand-by alert basis, but did not put its complete disaster program into effect. San Antonio hospitals, Mr. Garrett said, were in constant touch with one another by radio.

HOUSTON HOSPITALS HELP

Houston was also a center for

Hospitals throughout the entire Texas-Louisiana coastal area performed remarkably in the battle against Hurricane Carla. The photographs on these pages —while illustrating the specific problems at a few hospitals— represent the momentous tasks that faced almost every hospital touched by Carla.



(ABOVE) A corridor in John Sealy Hospital, which is normally orderly and unobstructed, is shown lined with refugees from Hurricane Carla. A spokesman for the hospital said people "parked where they could"—and waited out the storm. (BELOW) Residents, interns and medical students at John Sealy Hospital wore red arm bands for identification and to gain access to patient care areas where only essential personnel were admitted. Two members of a medical team are shown here getting instructions from a medical team captain.

(LEFT) Hospital personnel wait for antityphoid injections at the typhoid immunization center at John Sealy Hospital. It was estimated that 35,000 people in the hurricane area were innoculated. (RIGHT) A nurse prepares to give an antityphoid injection in the mass inoculation of John Sealy Hospital personnel. The possibility of typhoid was great because of polluted flood waters, adding another burden of concern to Texas hospitals. An ambulance operated as a mobile immunization center for Galveston area residents.

many evacuees. At the 414-bed Jefferson Davis Hospital, A. S. Reaves, administrator, reported that the hospital's complete, formal disaster plan was put into effect. The hospital staff was on duty for from 48 to 72 hours. Staff members used a nurses' dormitory for sleeping and staff people who had children who could not be left alone brought them to the hospital. Even the hospital's director of nursing took on baby sitting chores, Alice Barker, R.N., nursing supervisor, said.

Two clinics were set up as wards with 20 beds each, and additional beds were set up in other hospital facilities. Arrangements were made for an intensive treatment section, a burn ward and a triage area. In its permanent facilities, the hospital had 78 beds available for adults and 13 for children. The engineering staff was fully mobilized and also stayed at the hospital during the whole alert. Engineers were needed to see that the hospital's stand-by generator system functioned properly. Auxiliary power

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was needed briefly.

Although Jefferson Davis Hospital did not take in evacuees from coastal hospitals, care was provided for refugees housed in temporary shelters in Houston.

Maynard W. Martin, M.D., administrator of St. Luke's Episcopal Hospital and Texas Children's Hospital, reported that 11 people, evacuated from Little York Hospital in Houston because of power failure and flooding, were admitted to his institutions. Most staff members, he reported, stayed in the hospital for 48 hours during the storm. No difficulties because of either power or telephone failures were experienced. The hospital entrance was boarded up, but no damage took place.

Leigh J. Crozier, M.D., director of Hermann Hospital, said that hurricane winds broke 40 windows at his hospital and a large plate glass window in the hospital's professional building. Despite power failures in the city, the hospital had no problems with electricity or telephones and was in frequent contact with other Houston hospitals. Suppliers of food brought in additional food without being asked, Dr. Crozier said. When the hurricane alert began, the 675-bed Hermann Hospital had a census of approximately 90 per cent, and all elective surgery was postponed.

The hospital accepted 40 patients evacuated from Freeport Hospital, Freeport, Tex. Others from Freeport went to Methodist Hospital, Houston, when the Freeport area was evacuated. In most cases, because of the emergency conditions, the patients' own physicians treated them at Hermann Hospital.

John Hayes, administrator of Hedgecroft Hospital, and president of the Houston Area Hospital Council, reported that 200 to 500 beds were available at all times in 35 of Houston's major hospitals during the hurricane threat. "It is obvious that doctors and hospital administrators took notice of a possible emergency by discharging those patients who could be cared for at home . . . ," the administrator said. Texas State Women's College of Nursing provided student nurses for hospitals and shelter areas in that city. Mr. Hayes reported that his hospital lost power momentarily, but that power requirements were met by use of the hospital's stand-by generator.

Mr. Hayes, whose council includes 39 hospitals in the nine-county disaster area, reported that 34 patients, two of whom were ambulatory, were removed from the Denver Bend Geriatric Home to an inactive hospital at Ellington Air Force Base outside Houston.

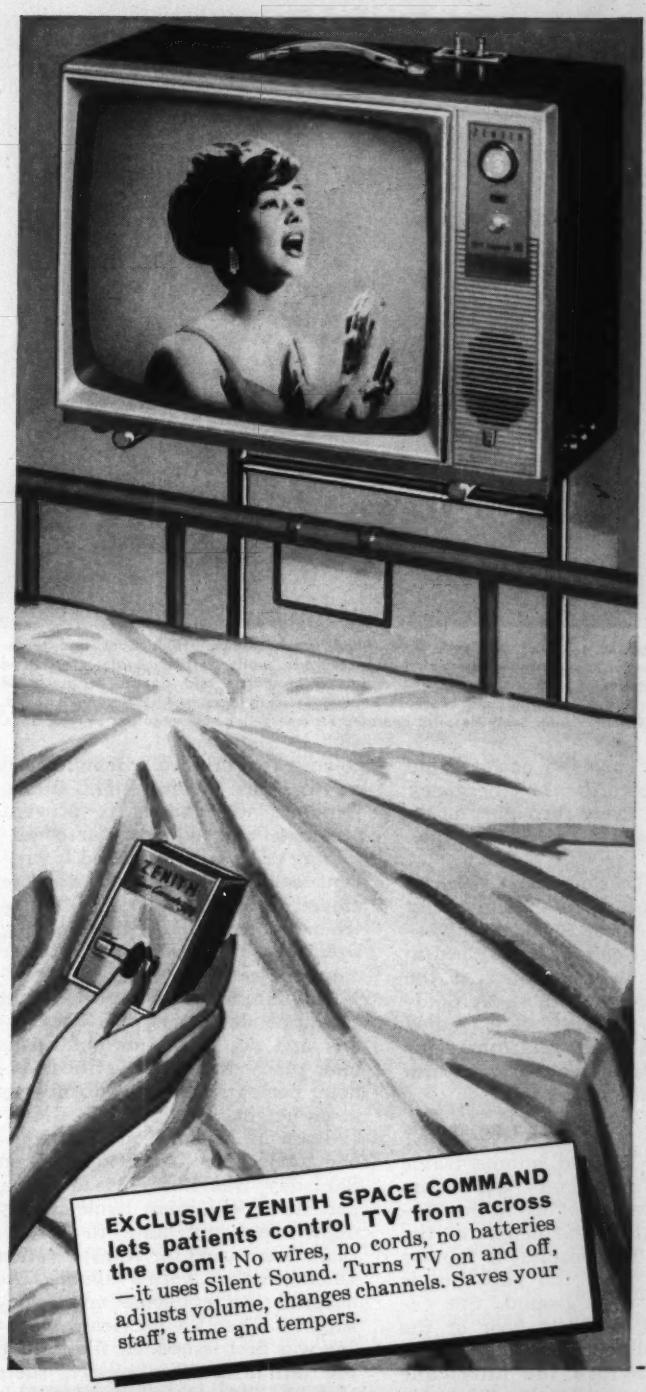
THE JOHN SEALY SAGA

John Sealy Hospital, one of the University of Texas Medical Branch Hospitals in Galveston, was one of the hardest hit of the hospitals that stayed open during the hurricane. Some 3000 to 3500 nonmedical refugees were given food and shelter at Sealy Hospital during the emergency. The 852-bed hospital had a census of 685 on the Wednesday following the hurricane. On Thursday, 45 people were admitted with injuries sustained when the porch of a Red Cross Shelter collapsed. It had been rumored at first that 500 people were injured at the shelter and the hospital responded accordingly.

Lack of power seemed to be the big problem, according to Daniel J. Bobbitt, director of University of Texas Medical Branch Hospitals, who reported that 30,000 pounds of hospital laundry were trucked to the M. D. Anderson Hospital and the Rice Hotel, Houston, when water pressure became inadequate for the hospital to produce enough steam to operate its laundry. The food service department used the steam during the day and the central supply department used steam at night for autoclaving. Steam for any other hospital services was not available.

The basement of the building was completely flooded and water was 12 feet deep in many places in the hospital. A $50,000 loss was sustained by the hospital when the pharmacy, located in the basement, filled with water. The Galveston Fire Department pumped out the flooded pharmacy. Damage to air-conditioning equipment, compressors and other equipment in the basement may bring the total loss to $1 million. Only one surgical room and a few rooms for cardiac patients were air-conditioned during the disaster.

As late as September 15—several days after the hurricane had reached its peak in Galveston—the hospital was still operating partially on emergency generators put together by the hospital's engineering staff, and parts of the hospital were still without electricity. Radiological equipment was only partly operative because of power problems. For several days, the hospital reported, water service was available to only four of the nine floors of the hospital, and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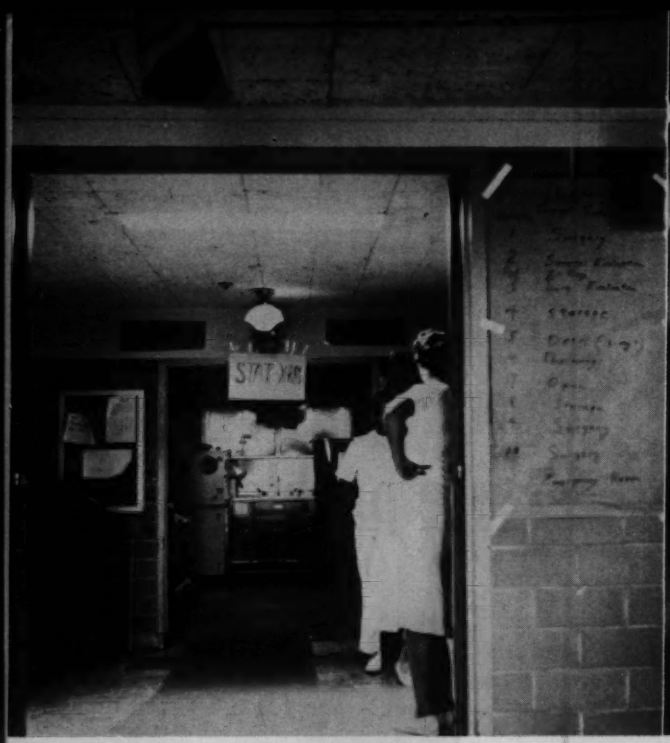


(LEFT) Signs of efficient emergency care could be seen throughout John Sealy Hospital. Shown here is a triage, or evacuation center, set up to expedite diagnosis of patients and direct them to the proper area for emergency care. (RIGHT) In the basement of John Sealy Hospital a workman attempts to clear the debris which resulted when 8 feet of flood water filled supply rooms. High tides and water pressure caused protective concrete walls to disintigrate. The flood caused thousands of dollars in damages and dozens of pieces of essential and auxiliary equipment were damaged or decommissioned. John Sealy Hospital operated on emergency equipment for several days.

pressure was insufficient for toilet facilities on the upper floors. A portable power plant was expected to arrive from Houston.

The hospital's emergency room was moved into an operating room and only emergency surgery was permitted. Only emergency admissions were made. Because of the hot water shortage, dishwashing became a problem; paper plates, as well as cold cuts and bread, were brought in from Houston.

The assistant director of Hermann Hospital, Houston, Charles Cooper Jr., formerly with John Sealy Hospital, returned to Sealy after the hurricane subsided to relieve Sealy administrative personnel who had been working long hours without sleep.

The island city of Galveston, already suffering from the toll of two days of Carla's wind and rain, was hit another blow on September 13 when two hurricane-spawned tornadoes killed at least four persons and injured an estimated 200. Many lives were saved because people who would normally have been in the path of the tornado had been evacuated to hurricane shelters.

John Sealy Hospital took in many of the seriously injured from the tornado. The hospital received injured from other areas struck by tornadoes. Supplies, such as snake bite vaccine, barbiturates, disinfectants and spools of power cable for use in operating the emergency power unit, were brought in by Army amtrack from La Marque, Tex.

John B. Truslow, M.D., executive dean and director, University of Texas Medical Branch, Galveston, said that 63 persons injured in the tornado were treated at the hospital. Twelve of these were admitted and the rest were treated and dismissed. He said others injured were treated at various storm shelters in the city.

SCENE AT ST. MARY'S

Sister M. Wilford, administrator of St. Mary's Infirmary, Galveston, reported a census of 200 in the 211-bed hospital at the height of the hurricane. The hospital is four or five blocks from the gulf, but is situated on high ground. She reported that the first floor of the hospital had been evacuated on the Saturday before the hurricane struck. Approximately 400 refugees from the hurricane received food and shelter in the hospital nurses' residence, and 350 others stayed at the hospital. Twenty elderly, bedridden people who lived at home were admitted to the hospital for medical reasons at the request of their doctors.

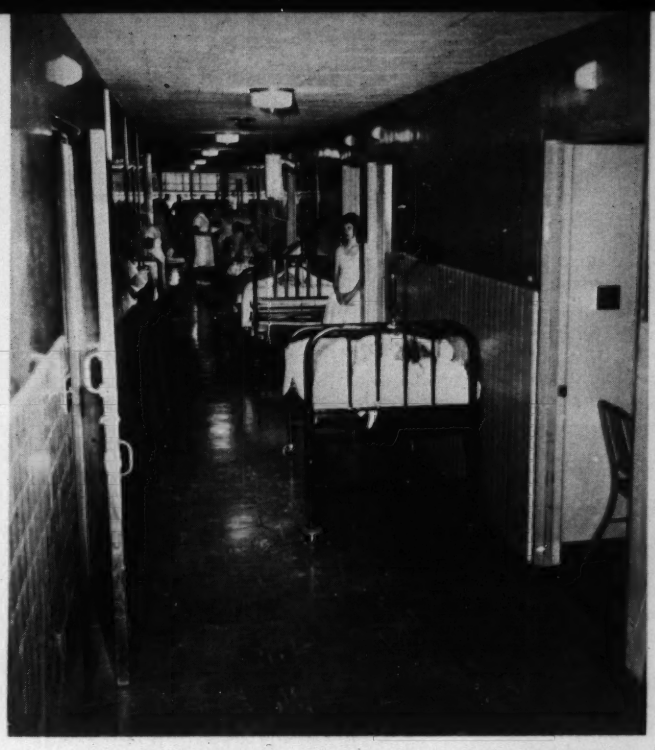
Sister M. Wilford said normal electric power was cut off for 24 hours, but auxiliary emergency power was utilized. Switchboard service was off for eight hours. Windows were taped to prevent breakage and window air-conditioning units were removed to prevent leakage. Medical records were moved to a higher floor at a time when it seemed likely that flooding would occur; however, no water damage resulted.

The administrator reported that two appendectomies, two Caesareans and six other normal births took place during the critical 48-hour period when the storm was at its height.

Sister M. Wilford said that anyone who came to the hospital on Saturday was not able to leave, and those who went home Friday night were not able to return. Boats were used for transportation whenever they were available. The hospital had collected emergency supplies when the hurricane warning was first issued. At the time of the administrator's report, there had been no injuries and people were "very orderly"; however, the hospital was beginning to conserve food supplies.

One of the serious obstacles for Galveston hospitals was the lack of utilities; notably, suitable water for sanitary and drinking purposes. Electricity and telephone service were also knocked out.

The hurricane struck Port Arthur Sunday afternoon. The city



(LEFT) Beds line a corridor in Galveston County Memorial Hospital, La Marque, where refugees from Hurricane Carla found shelter. Hundreds of persons were given space in the hospital's lobby and hallways. (RIGHT) In Galveston County Memorial Hospital, a mother and child, evacuees from Texas City, settle down on blankets on the floor. Like hundreds of thousands of others, they fled their home when warnings of Hurricane Carla were announced. The number of refugees sheltered at the hospital rose to 450 before the hurricane died down.

had been ordered evacuated on Saturday, and from Saturday night to Sunday, 72 patients, by one report, were transferred from St. Mary's Hospital in Port Arthur to Hotel Dieu Hospital and St. Therese Hospital in Beaumont, Tex. Baptist Hospital in Beaumont also received some patients from St. Mary's Hospital and from Park Place Hospital, a one-story hospital that had to be completely evacuated.

After evacuation of patients whose conditions were least serious to make room for evacuees and those who were injured, St. Mary's took in approximately 80 evacuees —most of them from other hospitals and rest homes in the city. The transfer of patients was made by ambulances, a call going out to every ambulance company to contribute one ambulance.

Sister Mary Cyril at the hospital reported that St. Mary's used a disaster plan, and that a civil defense station had been set up in the hospital. Civil defense authorities supplied the hospital with cots, blankets, fresh water and an emergency generator. At the time of her report, food, water and electricity were still available.

Sister Mary Cyril also reported that some of the hospital's personnel had evacuated with their families when warnings were given, but others stayed at the hospital.

In Beaumont, 17 miles north of Port Arthur, a hospital was set up in Lamar State College of Technology. By Sunday night, there were 120 patients sleeping on cots on the big, new basketball court of the Lamar Tech gymnasium. Two nurses and two doctors—volunteering their time on rotating shifts—were on duty at all times. The Red Cross provided 50 cots, and approximately 5000 blankets were supplied by the nearby Air Force base.

By Monday night, with Carla past but the flood tide still high, the gymnasium-hospital, supervised by Mrs. Ida Mae Hebert, supervisor of the Beaumont Municipal Hospital, was housing 250 patients, nurses and volunteers. The hospital was set up to accommodate patients from South County Hospital, who were most easily evacuated to make room for possible casualties resulting from the hurricane.

HOSPITALS HOUSE EVACUEES

Hospitals in Corpus Christi did not evacuate patients, but did feed and house several hundred nonpatient evacuees. Edward Glaze, assistant administrator of Memorial Hospital, reported that the hospital took in mostly relatives of hospitalized persons and that there were no casualties. He said that the cafeteria served all evacuees—personnel, patients and families of patients—and that food held out because the 36-hour warning gave ample time to stock and prepare food. He said water and electricity were available, but an emergency generator was on hand in case of a city power breakdown. The hospital found it necessary to move some of its patients to the leeward side of the building in order to protect them from water and broken windows.

Mr. Glaze reported that almost all personnel had come in and had worked overtime. He said the hospital was adequately staffed and morale was good. Ten physicians were standing by at all times, and the only real difficulty encountered was in the transportation of nursing personnel and other members of the hospital staff.

The Danforth Hospital in Texas City put its disaster plan into effect, but did not evacuate all of its patients. Adequate care for 25 or 30 patients was provided by 67 hospital personnel, including four registered nurses. There were four physicians standing by at all times.

It was reported that all patients were moved to the second floor to maximize safety and minimize wind and water damage. Approximately one foot of mud and rain was deposited in the lower floor, x-ray, laboratory and physical therapy areas. Emergency lighting

facilities were utilized at the hospital for an obstetrical delivery.

EMERGENCY HOSPITAL EXPANSION

Galveston County Memorial Hospital in La Marque, outside of Texas City, which stayed open during the hurricane, reported a census of 78 adults and 12 babies on the Saturday preceding the hurricane. The hospital picked up 80 medical admissions and 15 more babies before and during the storm. Of the 80, some 13 critical patients were brought to the county hospital from Danforth Hospital, Texas City, and seven patients were admitted from Texas City Hospital. Three nursing homes sent patients.

Saturday night the hospital provided care for 340 refugees; the number rose to 450 before the storm ended. Cots and surplus beds were used by the hospital, but some refugees had to sleep on

(Continued on page 123)

IN THE WAKE OF CARLA—

Louisiana Hospitals Battle Tornadoes, Find Two Major Flaws in Preparedness

The lack of radio communications and the limited emergency electrical supply were two obstacles hindering disaster services in some Louisiana hospitals when tornadoes—offspring of Hurricane Carla—ravaged the state's coast last month.

Joseph W. Hinsley, administrator, Lake Charles Memorial Hospital, said, "The storm has brought greater realization of the need for external communications and independent electrical generators."

Mr. Hinsley reported that Lake Charles had received advance warning of the hurricane both by commercial radio and a short wave radio network. Three hospitals in Lake Charles—St. Patrick's Hospital, Lake Charles Charity Hospital and Lake Charles Memorial Hospital—were transmitting over two short wave channels, with Lake Charles Memorial Hospital acting as the base station with direct radio communication with the fire, police, sheriff and air base. The three Lake Charles hospitals and one in Sulphur, La., were in constant contact with each other on a 24-hour basis. Mr. Hinsley said "this gave a greater feeling of security to each hospital . . ."

CHIEF PHARMACIST at John Sealy Hospital, Franz Geisz, examines damage caused when flood waters invaded the hospital's basement pharmacy. Damage was estimated at $50,000. A single lamp, operating on auxiliary power, provides the only light.

According to Mr. Hinsley, who obtained reports from hospitals in Kaplan, La., and Hodge, La., a definite lack in communications and electrical supply was evident.

When a tornado struck Kaplan on September 10, killing one child and injuring 37 persons, it left the city without electricity or telephone service.

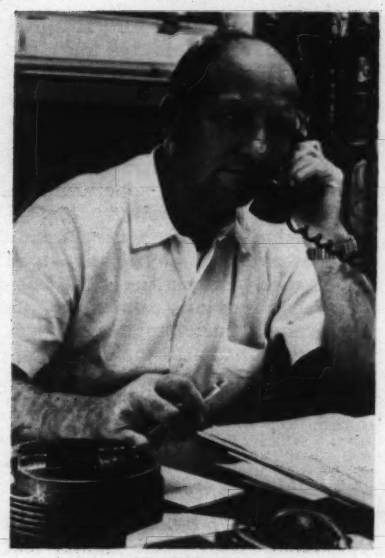
Junius J. Fangay, administrator of the 31-bed Abrom Kaplan Memorial Hospital, said the hospital was without any form of communication until a radio equipped police care arrived. The police car was pressed into service as a radio communications base, and proved of vital importance in obtaining doctors and nurses from surrounding towns.

Five nurses came to Kaplan from Lafayette, four from Abbeville and New Iberia, and two from Lake Charles. Ten doctors came from New Iberia and Abbeville. There were 36 persons in need of medical care, 31 being admitted to the hospital at Kaplan and the others to the Charity Hospital in Lafayette.

When a tornado struck the town of Hodge, 32 patients were taken to the Hodge Clinic, where four registered nurses and four practical nurses were on duty. Twenty-five of the patients were treated and discharged and seven remained as inpatients.

The hospital, which had no electricity and no emergency electrical generator, functioned with battery lights, and even flashlights. Its communications system was dependent entirely on the state police or sheriff's car. The hospital was out of communication with personnel who had gone to the scene of the disaster, and it had no way of being advised as to the number of casualties to expect until they arrived at the hospital. Four victims died enroute to the hospital, and of the seven inpatients, one died.

In Jonesboro, La., four persons were killed and 25 injured (six critically) when a tornado touched down. An emergency generator was sent to the small hospital in Jonesboro after it reported complete power failure. ■



DR. FLEMING

the floors, according to George M. Fleming, Ph.D., administrator.

Normal electric service was cut off from the hospital when power lines were downed. The hospital's auxiliary power went into operation, but even this power source failed for 20 minutes when water mixed with the diesel fuel. No damage was done by the complete power failure, Dr. Fleming said.

The hospital has its own well and water supply, but gets some water from Texas City. The Texas City water comes from a source that was not contaminated by water driven in by the hurricane, although some Texas City water was unusable.

Window air conditioners were pulled out by the hospital's engineers to prevent wind-driven water from entering the building. Plate glass entrance doors were sand bagged, and the lobby converted into an obstetrical waiting room. Twenty-four snake bite kits were ordered along with typhoid serum to inoculate refugees returning to homes where water and sewage services had failed. Laundry was done whenever intermittent city electricity was available. No laundry shortages were experienced, Dr. Fleming said.

Telephone service to outside points was lost for two and one-half days, but the hospital was in contact with county civil defense headquarters in Texas City by radio. At one point, the administrator reported, two-way contact was completely cut off for five hours. No critical shortages developed during that period.

Sealy Hospital in Galveston sent six medical students to assist at Galveston County Memorial Hospital, which already had two medical students on duty. After the storm subsided, eight Baylor University Medical School students went to the hospital. The Veterans Administration Hospital in Houston, through the Houston Area Hospital Council, supplied five registered nurses.

Food service, Dr. Fleming said, was handled without incident. The hospital's conveyor system was operated by auxiliary power, and paper plates and plastic utensils were used.

After the storm, three typhoid immunization stations were established in the area—including one at the hospital. An ambulance operated as a mobile immunization center. It was expected that 35,000 people in the area would be inoculated.

SITUATION COULD BE EASED

Dr. Fleming suggested that some of his hospital's problems could have been alleviated if telephone and power cables had been underground. He also said that retaining walls around the roofs should have vents so that water could have run

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off instead of "turning the roof into a swimming pool". Dr. Fleming also said that the new 188-bed addition to his 90-bed hospital would not have roll-out windows. He said two small solariums could not be used as emergency patient rooms because it was feared that the windows would blow open.

Hospitals in Victoria reported only two minor accidents and two incidents of snake bite during the hurricane. Administrators highly praised both physicians and hospital staffs.

As a precautionary measure against 100-mile-an-hour winds, hospitals in Victoria put disaster plans into effect. Medical staffs were placed on a 24-hour rotating call system, and although no extra shifts of hospital employees were required, it was reported that all employees returned to the hospital without being called under the disaster plan. An auxiliary electrical system was available, but was not required.

The Citizens Memorial Hospital, in addition to caring for a full patient load, rendered aid and shelter to more than 150 refugees.

The Calhoun Memorial Hospital in Port Lavaca reported that the hospital suffered wind and water damage after all of the patients had been evacuated to Citizens Memorial Hospital in Victoria. The hospital lost its front door and numerous windows. Operating on its emergency generator for 56 hours, the hospital, with 12 employees and two physicians, stood by to receive casualties. The hospital had recently rehearsed its hurricane disaster plan and was prepared for the storm. Many containers of fresh water and plastic bags for waste disposal were on hand.

'OPERATION CLEAN-UP'

The problem of clean-up operations in the hurricane area still remained. Gov. Price Daniel met with the mayors of several of the hardest hit cities and with civil defense directors to survey the damage and to coordinate relief efforts. He indicated hope that the state would be able to take care of its own rehabilitation problems and praised the mass evacuation—the largest in advance of a natural disaster in history.

The Small Business Administration in Washington declared the hurricane areas disaster areas, thereby permitting home owners, business firms, churches and charitable institutions, such as hospitals, whose property was damaged, to apply for reconstruction loans at 3 per cent interest.

The Office of Civil Defense and Defense Mobilization in Washington has ordered a federal disaster relief center set up in Houston. Subcenters were established at Lake Charles, La., and Corpus Christi, Tex.

ACCOLADE FOR HOSPITALS

According to a report by the Texas Hospital Association, "Texas truly can be proud of the outstanding facilities and services provided for its citizens by the voluntary, governmental, church and proprietary hospitals throughout the state.

"Hurricane disaster plans were put into effect in hospitals all along the Gulf Coast and several hundred miles into the interior of the state as Hurricane Carla approached.

". . . hospital administrators throughout the affected area were high in their praise of medical staff and hospital personnel for the services rendered to patients and refugees of the storm." ■

six sizes
a thousand and one uses

The wide range of sizes of 'VASELINE' STERILE PETROLATUM GAUZE U.S.P. gives it a thousand and one uses in the hospital and the office treatment room. As a pressure dressing in surgery . . . an occlusive dressing in burns . . . an emollient dressing on dry and nonacute skin lesions . . . a packing in nose, eye, and ear procedures . . . here is a dressing convenient to use and of guaranteed, sealed-in sterility.

Provided in a Range of Sizes for Every Indicated Need

in disposable plastic tubes • 1/2" x 72" selvage-edged packing
in heat-sealed foil envelopes • 1" x 36" strip . . . 3" x 3" pad, opening to 3" x 9" strip . . . 3" x 18" strip . . . 3" x 36" strip . . . 6" x 36" strip

'Vaseline' Sterile Petrolatum Gauze U.S.P.

Professional Products Division • Chesebrough-Pond's Inc., New York 17, N. Y.

'Vaseline' is a registered trademark of Chesebrough-Pond's Inc.

Questions to be answered before the architect puts pencil to paper

(Continued from page 54)

But well planned and developed green areas are of high value. Have these areas been properly allowed for early in the program or are they to be paid for with funds that may be left over? The grounds can be developed into a public relations asset when their development is placed in the hands of skilled planners. Involved here are not only trees and shrubs but also adequate parking areas, traffic circulation and lighting.

The architect has many responsibilities, and, fortunately, the public becomes more aware of his responsibilities and his services every year. A painstaking study of function is one of his responsibilities, whatever the design problem may be. Competent guidance of the client is another.

However, the architect sometimes wonders if the client is fully aware of his own responsibilities. Frequently, the client has been known to minimize, or else not fully realize, his responsibilities as a member of the planning team and assumes a difficult attitude of bill-payer only. But building a beautifully complex structure like a hospital requires a well modulated team effort if success is the goal, and it is essential that function be studied with the determination that it be satisfied.

There is every reason to believe that function and its important counterparts can be molded into a successful structure in which the patients' needs will be satisfied to the point of their comfort, both esthetical and psychological, and, we trust, physical. Some final questions may be these: Is this building to be a place to which a person is condemned because he is so unfortunate as to be sick? Or is it to be a place pleasant to behold, having qualities of therapeutic usefulness inherent in its restful beauty?

This entire effort, from the initiating conference until the move-in date, has to be a team effort to provide the most practical, efficient enclosure of the environment necessary to meet the needs for the best hospital care. ■

Management tools for the executive housekeeper

(Continued from page 93)

ly removable by the addition of a common chemical to the wash water.

Many new chemical changes are being made in wall finishes. The first of the wonder paints was the odorless one that permitted the hospital to paint a room in the morning and use it that night because the mineral spirit "thinner" dried so rapidly.

The competent executive housekeeper, therefore, is one who understands the changing technology of her field and who knows how to incorporate significant advances into her departmental operation. She is able to streamline her department to make it more effective, and she is able to harmonize its function with those of other hospital services to provide better patient care. ■

Still Another SUCCESSFUL Hospital Fund Campaign

by Burrill,

GOAL $400,000

AMOUNT RAISED $432,214

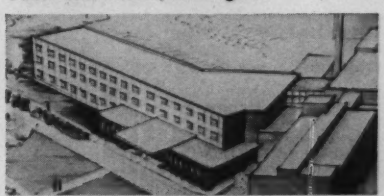
(BACKGROUND NOTE: *What could justifiably be called an adverse community climate, prevailed in Sault Ste. Marie at campaign time. Both letters make specific mention of this fact.)*

"It is not unusual for a community to feel that a fund drive may not meet with public approval and subsequent success. In our community, negative attitudes seemed justified, in light of existing economic conditions. The resounding success of our fund drive attests to your organizational ability.

I am convinced that our success is directly attributable to the fact that we engaged the professional services of your organization."

Kenneth J. Shouldice, Ph. D. Administrator

THIS TIME FOR
WAR MEMORIAL HOSPITAL
Sault Ste. Marie, Michigan



"One of the finest things that has ever happened in this city was the eminent good fortune in the selection of your firm to conduct the campaign for the new hospital building.

The goal seemed to many absolutely impossible due to extreme pessimism prevailing because of our having lost five various industries all within the past five years. But the goal was met and exceeded by a wide margin.

I most heartily recommend your services to any city."

James Robertson, General Chairman

"Yesteryear" solutions are not good enough to meet *today's* specialized hospital fund-raising problems. Though Burrill, Inc., as one of the oldest firms in the fund-raising profession, has years of experience, B/I's answers to *today's* needs come from last month's, yesterday's and today's experiences.*

Today's hospital financing demands incisive, quick thinking, flexible fund-raising management adjusted to your needs and community circumstances *today*. Burrill campaign directors and co-directional executives are men with enthusiasm, mature judgment, good health and the capacity to get today's job done *today!* They are doing just that—every day!

**We have served hospitals 31 more times in the past 24 months.*

If you are considering a fund-raising program,
Call us for consultation. There is no cost or obligation.

THE FUND RAISING LEADER

Burrill, Inc.

Kansas City 12, Mo. Suite 200, 424 Nichols Road
Washington 5, D.C. Suite 500, 734 Fifteenth St., N.W.
San Francisco 4, Calif. Suite 202, 400 Montgomery St.

Accepted for listing by the American Hospital Association

CLASSIFIED ADVERTISING

Classifications: Classified advertising accepted to run under the following headings: 1—Services; 2—Instruction; 3 — Wanted; 4 — For Sale; 5—Positions Wanted; 6—Positions Open; 7—Miscellaneous.

Transient Rate: Thirty-five cents a word; minimum charge $5.00 per insertion.

Contract Rate: Six-point body lines, 13 pica columns, $1.60 per line; eight-point display lines $2.00 per line. Five per cent discount for twelve-insertion contracts with no change of copy. Ten per cent discount for twenty four-insertion contracts with no change of copy.

POSITIONS OPEN

HOSPITAL FOOD SERVICE DIRECTOR: Management Company, nationally recognized as a leader in its field, offers qualified candidate exceptional opportunities in dietary department management. The man we are interested in holds a degree from a school with a specialized program in food and nutritional Management. He would have from five to ten years of successful dietary department management experience in a hospital with 300 or more beds. He would possess a working knowledge of the Mechanics and logic of dietetics and nutrition. He would be an organizer, capable of training dietary department employees in their duties and work detail. Lastly, our man would be career-centered, interested in growing within our organization. If you feel you qualify as "Our Man", send a detailed resume stating age, educational background and employment record covering the last ten years of your employment. All inquiries will be held in strictest confidence. Address HOSPITALS, Box K-83.

DIETITIANS ADA: (female) National management organization with impeccable professional reputation offers career-minded ADA therapeutic and administrative dietitians exceptional opportunities as members of its professional Hospital Division staff. Attractive starting salary. Traveling moderate to heavy — depending on operational requirements. Paid traveling expenses. Future based on individual growth potential. Submit complete resume, including education, internship and work background. All inquiries held in strictest confidence. Address HOSPITALS, Box K-48.

EXECUTIVE HOUSEKEEPER: A very desirable position available immediately for an experienced housekeeper to carry on a well organized training program and direct our large housekeeping staff. We are a 450 bed general hospital with complete modern facilities. You will receive many employee benefits including an excellent retirement program. Please mail your professional qualifications to the Personnel Director, Butterworth Hospital, Grand Rapids 3, Michigan.

ANESTHETIST: Nurse to work with one other anesthetist. Accredited, 68 bed general hospital. Apply to Administrator, Marion Memorial Hospital, Marion, Ill.

EXECUTIVE HOUSEKEEPER: $530 to $644 monthly. Requires college graduation, two years administrative housekeeping experience; or high school graduation, four years administrative experience. Direct staff of 100 in large teaching hospital. All civil service benefits. Apply to Alameda County Civil Service, 232 14th Street, Oakland 12, California.

CLINICAL INSTRUCTORS for Medical-Surgical Nursing, Pediatrics and Obstetrics. NLN accredited Diploma School, 180 students, 450 bed general hospital. Educational opportunities in nearby New York City and Philadelphia. Freedom to teach in a modern setting. Apply Director of Nursing, Delaware Hospital, 14th and Washington Streets, Wilmington 99, Delaware.

ANESTHETISTS-NURSE; immediate openings in 116-bed general hospital near Pittsburgh. Department headed by Anesthesiologist. Salary open. Liberal employment policies. Apply Administrator, Beaver Valley General Hospital, New Brighton, Pa.

ASSISTANT MEDICAL RECORD LIBRARIAN for 400 bed accredited private general hospital. Will consider recent graduate. Liberal salary range and employee benefits. Excellent working conditions. In one of midwest's foremost institutions. Centrally located in city and convenient to outstanding residential and shopping facilities. Contact Personnel Director, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

EXECUTIVE HOUSEKEEPER: Excellent opportunity in a large modern 500 bed hospital, with fine equipment, and a well staffed department. Generous personnel policies. Apply Personnel Director, The Christ Hospital, Cincinnati, Ohio.

CASEWORKER—for department of cardiology to work closely with physicians in both patient care and teaching. Work is primarily centered in the cardiology and hypertension clinics of university hospital, but patient contact will also be a responsibility. Weekly Cardiology Conferences provide the case worker the opportunity to express her views and to progress in professional education. Salary begins at 4800 for MSW applicant. Contact: Mrs. G. Montgomery, Acting Director, Department Medical Social Service, Firmin Desloge Hospital of Saint Louis University.

STAFF DIETITIAN: Excellent opportunity for Therapeutic Dietitian in 500 bed hospital, with intern resident program, school of nursing, salary open, commensurate with background, liberal benefit program. Apply Personnel Department, Christ Hospital, 2139 Auburn Avenue, Cincinnati, Ohio.

REGISTERED PHYSICAL THERAPIST: New department. 114 bed hospital. Salary open. Write to: Administrator, Dickinson County Hospitals, Iron Mountain, Michigan.

OUR 65th YEAR

Founders of the personnel counseling service to the medical profession, serving medicine with distinction over half a century.

RAndolph 6-5682

Ann Woodward offers her long established, strictly confidential service to hospital administrators, physicians, nursing executives and others wishing to relocate in the medical and hospital fields. Opportunities throughout America and abroad. To the institution reorganizing or augmenting its staff, brochures of those qualified to head medical and ancillary departments or for staff posts will be submitted immediately upon request.

The Best Way
TO FIND A POSITION

To the person confronted with the problem of finding a position in the hospital field, Burneice Larson, founder of the counseling service for the physician, offers the services of The Medical Bureau.

All negotiations strictly confidential.

Opportunities in all parts of America, including countries outside continental United States — with clinics, universities, public health agencies, industry, and hospitals.

Please write today for our Analysis Sheet, so we may prepare an individual survey of opportunities in your particular field.

Burneice Larson

Chairman of the Board
THE MEDICAL BUREAU, Inc.
900 N. Michigan Ave. CHICAGO
for 40 years serving the profession with outstanding opportunities and competent, dependable personnel.

POSITIONS WANTED

ADMINISTRATOR desires 100-150 bed hospital, East, South, Southwest. 5 yrs. experience Hospital Administrator, 10 yrs. Director of Nurses. R.N. M.A. Assistant Administrator, large hospital. Address HOSPITALS, Box L-8.

Experienced laundry man desires job as MANAGER, ASSISTANT, or FOREMAN. Address HOSPITALS, Box L-13.

M. D. ANESTHETIST: Trained and experienced. Salary or fees. Can also assist as house doctor. Address HOSPITALS, Box L-12.

Drug Use in Public Medical Care Programs

(Continued from page 80)

that the American Public Health Association encourage welfare, health and other public agencies administering public medical care programs to adopt the policy of limiting public expenditures for drugs to those which are prescribed by their non-proprietary or generic names, and which are included in the U.S. Pharmacopeia, National Formulary (or Accepted Dental Remedies) or, if not included, have been approved by qualified formulary committees or by similar committees of experts."

Effective but low-cost Communications

Classified advertising is the lowest-cost method of advertising. It can serve your hospital effectively when you are recruiting employees or when you have used equipment to sell.

The classified advertising rate is 35 cents per word with a minimum of $5.00 per insertion. Deadline: 30 days before publication of the issue. Two opportunities are available each month. HOSPITALS is published on the first and 16th of each month.

Hospitals, Journal of the American Hospital Association
840 North Lake Shore Drive, Chicago 11, Illinois

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840 North Lake Shore Drive, Chicago 11, Illinois

Please schedule the following advertisement for the _____ issue(s)
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_____ Wanted _____ Services _____ Positions Open

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Signed _____

Title _____

Hospital _____

Address _____

City & State _____

☐ Check or Money Order Enclosed

☐ Bill the Hospital

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NEW Castle* POWERCLAVE with ELECTRILOCK DOOR

*Trademark Wilmot Castle Company

Open! Just push the button. Door swings out smoothly, silently—*effortlessly*.

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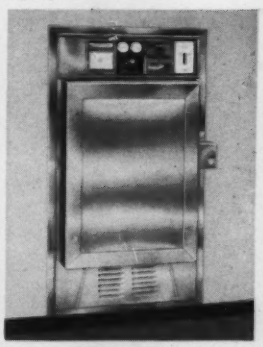

Lock! Touch the button—door swings shut, locks safely, starts sterile cycle. No handwheel to wrestle with.

SAFER . . . Just a touch of a button closes and locks the door. Steam tight seal is automatic—regardless of the operator's strength. And three separate features make it impossible to open the door under pressure.

EASIER . . . No handwheel to struggle with. It's all automatic. Closing and locking the door, sterilizing, opening the door—it's pushbuttons all the way!

MORE CAPACITY . . . New design of vessel and car increases load capacity. And improved exchange of air and steam reduces cycle time—particularly advantageous with high vacuum techniques.

THAN EVER BEFORE! POWERCLAVE is the first major re-design of hospital sterilizers in forty years. Yet you can fit it right into your present sterilization program—for approximately the cost of a conventional autoclave! Write for POWERCLAVE literature.

Castle

WILMOT CASTLE COMPANY, 1410 E. Henrietta Rd., Rochester 18, N. Y.

Subsidiary of Ritter Company Inc.

TO THE THIRD STAGE OF ANESTHESIA AND BACK—
EVENLY... RAPIDLY... UNEVENTFULLY

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ULTRASHORT-ACTING INTRAVENOUS ANESTHETIC From smooth induction to prompt recovery, SURITAL sodium (thiamylal sodium, Parke-Davis) provides specific advantages both for surgical team and patient. Adaptable to most operative and manipulative procedures, it assures a uniformly sustained plane of anesthesia, plus low incidence of laryngospasm and bronchospasm with minimal respiratory depression. And because SURITAL sodium rarely produces nausea or vomiting, it contributes significantly to greater patient comfort. See medical brochure for details of administration and dosage. 5974I

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